

Kentucky Adult Mental Health Case Management Level I Training Manual

This Manual Edition Prepared by:
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Division of Mental Health and Substance Abuse
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UNIT 1

INTRODUCTION TO COMMUNITY SUPPORT PROGRAMS AND CASE MANAGEMENT

Description:

This unit describes the backdrop from which case management has emerged as an indispensable element of the mental health service system. Topics discussed include a history of treatment, the deinstitutionalization movement, the community support movement, Kentucky's vision for services for adults with severe mental illness, the definition of case management, and the history of case management in Kentucky.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Identify a brief history of mental health treatment for adults with a severe mental illness.

2. Describe the origins and principles of the Community Support Movement.

3. Describe Kentucky's vision and philosophy for services to adults with severe mental illness.

4. Define Case Management.

5. Describe Kentucky's mental health adult case management history.

Introduction

This manual was written to help prepare you for one of the most important jobs in community mental health today. It will serve as a guidebook and resource manual that you can use as a companion in your work as a case manager. Like any new textbook or course of study, this manual should be considered just a beginning.

History of Mental Health Treatment

Beliefs about the causes of mental illness and approaches to the treatment of people with mental illness have changed a great deal in the course of our history. It is important to know something of this history to understand current values, philosophies and services. In early times, mental illness was believed to result from sin, possession by demons, or witchcraft. In response to this belief, "treatment" consisted of chaining people to walls, beating them, and using purges, emetics, and blood letting. Persons with mental illness were often found in unheated rooms, jails, and poorhouses.

Moral Treatment and Asylums

During the 19th century, social reformers spearheaded by Dorothea Dix in America began to advocate for more humane approaches for people with mental illness. Asylums, which provided kindness, retreat, security, and freedom from chains, were developed. The asylums were small and personal and did cure some acute mental illness. Other social, political, and economic forces, however, influenced the fate of the asylums. They were forced to absorb tremendous numbers of people, many who had chronic physical disorders, who were frail, elderly or who were simply poor or unemployed, as county costs shifted from county supported almshouses to state-supported institutions. The Kentucky Lunatic Asylum (now Eastern State Hospital) the first state hospital west of the Appalachians, was founded in 1816. Originally planned to be financed entirely by voluntary contributions, the property was offered to the state and became Eastern State Hospital when a financial crisis struck Lexington in 1819. Western State Hospital opened in 1848, and Central State Hospital opened in 1873. A fourth state hospital, Kentucky State Hospital, was built in Danville in 1940 and closed in 1977. Appalachian Regional Hospital (ARH) was opened in 1993 to provide access to community based psychiatric services to people living in eastern Kentucky.

Custodialism

The tremendous number of people in mental institutions, the lack of effective treatments for chronic conditions, and the lack of interest in people with severe mental illness led to the warehousing of many persons with mental illness with little hope for their improvement. The hope of the moral treatment asylum ended with custodialism... overcrowded and often dehumanizing conditions.

In much of the world, Emil Kraeplin is considered the founder of psychiatry. Kraeplin, whose major work was done between 1883 and 1926, focused on the severe mental illnesses. His major contribution was a description of the illnesses, two of which he called manic-depressive insanity and dementia praecox (later renamed schizophrenia by Bleuler). Prior to Kraeplin's description, all mental illnesses were considered to be part of the same conglomeration of symptoms and behaviors.

Deinstitutionalization and the Community Mental Health Centers Movement

Several factors converged to begin the movement toward deinstitutionalization. Reformers became alarmed about the conditions in state psychiatric hospitals, the negative effects of institutionalization on people, the infringement on rights and the rising costs of institutions. The discovery of the effects of neuroleptic medications on the symptoms of psychosis opened the door to the possibility of management of severe and persistent mental illnesses in the community. In 1953, the World Health Organization concluded that community based treatment rather than institution based treatment was essential for people with mental illness. The American Medical Association, the American Psychiatric Association and the Council of State Government all reached the same conclusion.

In 1963, President Kennedy signed the Community Mental Health Centers (CMHC) Construction Act and Amendments which provided for the construction and staffing of local mental health programs that were to provide services in the community rather than in isolated institutions. Although the enactment of this Act provided the impetus for community treatment, little planning went into developing comprehensive services to replace the limited care available for persons with a severe mental illness in institutional settings. Five essential services were identified for the centers: inpatient, outpatient, emergency, consultation and education, and partial hospitalization.

One unintended consequence of the CMHC movement was that it basically addressed people's need for mental health services without considering the other needs which state psychiatric hospitals had been meeting (e.g. housing, companionship, medical care, income). The CMHCCA also left out the needs of people with severe mental illness. By the mid 1960's many persons with acute illness who responded more quickly to medications were no longer in institutions. By the 1970's, hospitals began to release people with more severe and chronic mental illnesses, even though the community alternatives were not in place to assist them.

Deinstitutionalization is a complex concept. Leona Bachrach (1989) stated that deinstitutionalization was a movement that had three processes:

- **Depopulation** - a decrease in the number of persons in state hospitals because some are released into the community, others are transferred to another institution, and some die.

- **Diversion** - an initial referral to community services for those who could have been put in hospitals.

- **Decentralization** - the broadening of responsibility for care from a single service source, such as a hospital, to multiple and diverse settings.

Deinstitutionalization requires a connected, supportive community based network of services. By the mid-1970's, policymakers, government officials, and academicians generally agreed that the Community Mental Health Center (CMHC) system in and of itself was not sufficient.

The Community Support Program (CSP)

The first major response to the problems created by deinstitutionalization was an initiative at the National Institute of Mental Health (NIMH) called the Community Support Program (CSP) in 1978. In the CSP definition, case management was seen as the function which would integrate various interventions and assure that necessary services and supports were continuously available to persons formerly serviced in state hospitals. **The US Department of Health and Human Services (1980) stressed the need for case management in providing a comprehensive system of services.**

Mental health systems that serve persons with severe mental illnesses should be designed as Community Support Systems (CSS). A Community Support System (CSS) is defined as an organized network of caring and responsible people committed to assisting persons with long-term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community. (Turner and TenHoor, 1978).

CSP Principles

The original principles (Stroul, 1988) of the community support movement continue to be the distinguishing feature of community support services, and they include:

- **Services should be racially and culturally appropriate**. Services should be available, accessible, and acceptable to members of racial and ethnic minority groups and women. This principle is now expanded to include sexual minorities and persons with physical impairments.

- **Services should be flexible**. Services should be available whenever they are needed and for as long as they are needed. They should be provided in a variety of ways with individuals able to move in and out of the system as their needs change.

- **Services should focus on strengths**. Services should build upon the assets and strengths of clients in order to help them maintain a sense of identity, dignity, and self-esteem.

- **Services should be normalized and incorporate natural supports**. Services should be offered in the least restrictive, most natural setting possible. Clients should be encouraged to use the natural supports in the community and should be integrated into the normal living, working, learning, and leisure time activities of the community.

- **Services should meet special needs**. Services should be adapted to meet the needs of subgroups of persons with severe mental illness such as elderly individuals in the community or in institutions; young adults and youth in transition to adulthood; individuals with mental illness and substance abuse problems, developmental disabilities, or hearing impairments; persons with mental illness who are also homeless; and persons who are mentally ill and inappropriately placed within the criminal justice system.

- **Service systems should be accountable**. Service providers should be accountable to the users of the services and should be monitored to assure quality of care and continued relevance to client needs. Primary consumers and families should be involved in planning, implementing, monitoring, and evaluating services. This principle is now expanded to include explicit reference to consumer satisfaction, consumer outcomes and stewardship of public funding.

These principles are innovative and far reaching. They move from the traditional mental health center approach, acknowledge the indefinite nature of severe mental illness and call for a coordinated array of services to meet individual needs. Case management is viewed as the core of the community support system. The "human" link of a CSP system is considered to be a single person (or team) responsible for remaining in touch with the client on a continuing basis, regardless of how many agencies get involved (Turner and TenHoor, 1978)

Kentucky's CSP History

In Kentucky, persons with severe mental illness (SMI) were established as one of the top three priority populations by the Division of Mental Health in 1981. In 1982 Kentucky Revised Statute 210 gave special recognition to the needs of persons with severe mental illness, however, no funds accompanied the bill. In 1983, Kentucky received a National Institute of Mental Health (NIMH) Community Support Program Grant. These federal NIMH CSP funds were used to provide grants to CMHCs for community based services which included: education, training, parent support groups, clubhouses, and other innovative demonstration projects. These funds and services clearly marked the beginning of Kentucky's intensive community support effort on behalf of persons with SMI. Parents, consumers and concerned citizens began increasing the number of local support groups. Louisville and Covington family support groups formed. The groups in Lexington, Ashland, Owensboro and Henderson affiliated to become the Kentucky Alliance for the Mentally Ill (KAMI), which became a chapter of the National Alliance in 1984. The group changed their name to NAMI Kentucky in 1998.

In 1986, the Kentucky General Assembly provided two million dollars in state general funds for special projects to serve persons with a severe mental illness. Also, in 1986, the Comprehensive Mental Health Services Plan Act (federal Public Law 99-660) was passed. Since then, the adult portion of the CMHS Block Grant funds and the two million in state general funds (as well as a steady increase through the years) has been restricted for provision of community based services to adults with a severe mental illness.

Consumers began meeting concerned citizens and decision makers and joined in as key stakeholders. In 1988, consumers formed Advocates Taking Action in Kentucky/Mental Illness (ATAK/MI), a statewide consumer group which has fostered the development of many local groups. In 1998, the organization's name changed to Kentucky Consumer Advocacy Network (KYCAN).

The 1980's have been called "the decade of the brain" because during this time more was learned about the structure and functioning of the brain than ever before. This new information and new methods of studying the brain have led to major changes in ways in which mental illnesses are conceptualized and treated. Much more research is needed to definitively identify the specific causes of mental illness, but current research suggests that biological factors play a substantial part in major mental illnesses. We have come a long way from the initial stigmatizing beliefs that sin, parents, witchcraft, etc. caused mental illness.

Early in the implementation of the Comprehensive Mental Health Services Plan Act, Kentucky began a series of enlightening and provocative discussions with consumers, family members, providers, representatives of state agencies, advocacy groups, and others to adopt the following vision and philosophy statement on behalf of adults with severe mental illness:

Kentucky's Vision for Adults with Severe Mental Illness

Kentucky's vision for persons with severe mental illness is that they are empowered by their personal and individual choices and capacities, and will be able to live a life of dignity and hope in the community.

Each person will have available options for housing, income, productive work, medical and social services, transportation, education, and personal support equivalent to that of all citizens of the Commonwealth and adequate to meet individual wants and needs. The focus of all actions will be to protect and balance the rights and concerns of consumers, family members, and the larger community and to provide an environment that maximizes community integration and opportunities for acceptance.

Kentucky's Philosophy for Adults with SMI

- Consumers should retain the fullest possible control over their own lives and be empowered to make choices concerning the services and activities in which they will be involved.

- Families are a primary source for support and advocacy at the collective system level.

- The mental health services system should be comprehensive, flexible, culturally normative, and unified.

- The overall human services system should be seamless, continuous, and integrated in a way that consumers experience minimal difficulties in moving among its various components.

- The natural community should be a place where everyone will learn, finally, to live together, to respect each other's differences, to heal each other's wounds, to promote each other's progress and to benefit from each other's knowledge.

The 1990's have brought a breed of antidepressants and second generation atypical antipsychotic medications which for some have made a dramatic difference in reducing the symptoms of severe mental illness and/or have reduced the unpleasant side effects of earlier medications prescribed for some individuals.

In 2002, the Kentucky Department for Mental Health and Mental Retardation Services developed the following Vision, Mission and Values statements:

Our Vision

That all Kentuckians with mental illness, mental retardation/developmental disabilities, substance abuse disorders, and/or acquired brain injuries will be able to lead lives of dignity and hope in accordance with their personal and individual choices.

That the Department for Mental Health and Mental Retardation Services is recognized as the leader and innovator in development, administration and delivery of services and supports that are individually focused and cost efficient.

Our Mission

To provide leadership, in partnership with others, to prevent disability, build resilience in individuals and their communities, and facilitate recovery for people whose lives have been affected by mental illness, mental retardation or other developmental disability, substance abuse or an acquired brain injury.

Our Values

Respect…	We believe that all individuals are valuable, and that they have the potential for growth, and for the recovery of a meaningful, productive life.
Excellence…	We believe that service is collaborative, represents consumer needs, assures optimal use of public resources, and achieves the highest possible standard.
Choice and Self-Determination…	We believe that individuals should have the fullest possible control over their own lives.

Definition of Case Management

As Community Support Program Services developed and evolved, case management services became more clearly defined. There is good agreement about the core functions of case management for adults with mental illness; however, a commonly accepted definition of case management has been more elusive.

There are many widely accepted definitions for case management. The Kentucky Department for Mental Health and Mental Retardation Services has adopted the following definition of case management by the National Association of Case Management:

> **"CM is a practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of the individual's personal goals for community living."** (Hodge and Giesler, 1997)

This definition encompasses the core functions, recovery focus, and outcomes of case management and is supported by the following definitions from the Kansas Strengths Model and the Psychiatric Rehabilitation Model of case management.

The Kansas Strengths (developmental-acquisition) Model defines case management as **a form of personalized helping directed at connecting an individual to resources (internal-external) for improving their quality of community life.**

The Psychiatric Rehabilitation model defines case management as **a process by which persons with severe psychiatric disabilities receive support in negotiating for the various services that they both want and need.**

History of Case Management in Kentucky

Since 1982, the Cabinet has been required by Kentucky Revised Statute, KRS 210.04(7)(d), to assure "the availability of a case manager for each person with severe (chronic) mental illness". Funds, however, did not accompany this act. It was not until state general funds were allocated in 1986 that the Department for Mental Health and Mental Retardation Services' commitment to the statewide development of case management services began to take shape within the community. These funds supported at least two case managers in each of the Community Mental Health Centers. In 1991, the Department for Mental Health/Mental Retardation Services (DMHMRS) successfully negotiated with the Department for Medicaid Services (DMS) for the reimbursement of targeted case management for persons with mental illness. This collaboration of funding sources greatly enhanced Kentucky's ability to assure statewide availability of targeted case management.

The DMHMRS has maintained its commitment to case management by annually designating a specific amount of funds to each Community Mental Health Center for the continuation of adult case management services. The DMHMRS reallocates targeted case management funds from Community Mental Health Centers who cannot spend their allocation to other Community Mental Health Centers whose case management services have exceeded their case management allocation.

In addition, since 1990 persons who are receiving case management services are also given access to "wraparound" funds which have, as their focus, community stabilization. These funds are used for the purchase of non-recurring basic goods and services (such as clothing, rental deposits, and crisis and health care costs) necessary to achieve or maintain a stable community placement.

In response to a statewide survey of training needs, the University of Kansas provided Kentucky's first statewide case management training in the fall of 1986. The DMHMRS and the Department for Medicaid Services initially adopted the University of Kansas' developmental acquisition strengths model of intensive case management. In 2004, the DMHMRS added elements of the Psychiatric Rehabilitation model of Case Management from the Center for Psychiatric Rehabilitation through Boston University to case management training to form a Kentucky Rehabilitation and Recovery model. Case managers and their supervisors are required to be trained and certified within six months of employment.

In addition to Level I Case Management training, DMHMRS has expanded the training curriculum to include advanced courses (Level II) for the experienced case manager and case management supervisors. The Level II courses include access to evidence based or best practices in various areas including housing, employment, education,

medication, advocacy, co-occurring disorders, recovery, rehabilitation, special populations, multiculturalism and other case management issues.

Sources: (See bibliography in Appendix I):

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UNIT 2

WHO ARE CONSUMERS OF CASE MANAGEMENT SERVICES?

Description:

This unit will define eligibility criteria for case management services including the federal and state definitions of mental illness, the dimensions of mental illness and how mental illness impacts people's lives. Consumers are generally referred to case management services because their mental illness has caused significant disruptive episodes in their life. Their symptoms may have lead to one or more hospitalizations or may have affected their ability to manage aspects of their life or access useful community resources. Case Management is the process by which persons with severe mental illness receive support in negotiating for the various services that they both want and need to improve the quality of their life.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Discuss the federal and Kentucky state definitions of severe mental illness.

2. Describe the three dimensions used as criteria to determine severe mental illness - diagnosis, disability and duration.

3. Discuss the presentation of severe mental illness.

Definitions of Mental Illness

In order to distinguish the population of adults with a severe and persistent mental illness, federal and state definitions have evolved. Distinctions have consistently been made for this population along three dimensions: diagnosis, disability, and duration.

The Federal definition for severe mental illness, published in the Federal Register, May 20, 1993 is:

Federal Definition

"adults with a serious mental illness are persons:

- age 18 and over,
- who currently or at any time during the last year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to merit diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders.
- that has resulted in functional impairment which substantially interferes with or limits one or more major life activities."

These disorders include any mental disorders (including those of biological etiology) listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR or their International Statistical Classification of Diseases and Related Health Problems (ICD-9) equivalent (and subsequent revisions) with the exception of DSM-V codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic living skills (e.g. eating, bathing, dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses.

Kentucky Statutory Definition

Kentucky's statutory definition (KRS 210.005) defines mental illness as follows:

"'Mental illness' means a diagnostic term that covers many clinical categories, interpreted through reference to criteria contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and any subsequent revision thereto, of the American Psychiatric Association. 'Chronic' means that clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or that the individual has been hospitalized for mental illness more than once in the last two (2) years, and that the individual is presently significantly impaired in his ability to function socially or occupationally, or both."

Kentucky funding of case management services for adults limits the provision of the service to adults with a severe mental illness. Therefore, it is critical that case managers and their supervisors understand the working definition of severe mental illness.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) is used by many mental health professionals to assess and diagnose mental disorders. A diagnosis is separated into five parts known as axes. Each axis represents an aspect of functioning:

- Axis I describes mental and psychological functioning including psychotic disorders, mood disorders, and anxiety disorders
- Axis II includes developmental disorders and personality disorders
- Axis III describes physical functioning
- Axis IV describes environment stress level
- Axis V serves as a general indicator of how well or poorly an individual is functioning in daily life

The majority of diagnoses that fall within the criteria of severe mental illness are found on Axis I.

Another form of classification found in many medical settings is the *International Classification of Diseases, 4th Revision, Clinical Modification* sometimes referred to as ICD-9. The tenth revision of the International Statistical Classifications of Diseases and Related Health Problems was published in 1992, but has not been made official in the United States at this writing. The codes and terms provided in DSM-IV TR are fully compatible with both ICD-9-CM and ICD-10. (First, 1994 and Albaum-Feinstein, 1995).

Criteria for Severe Mental Illness

1. Diagnosis - is one of the following DSM-IV-TR eligible codes:

    a) Schizophrenia and Other Psychotic Disorders
        (295.xx; 297.1; 298.9)
    b) Mood Disorders
        (296.xx)
    c) Other (DSM_____) within state and federal guidelines

2. Disability - impairment in **two or more** of these domains of functioning:

a) Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social morals.

b) Interpersonal Functioning: How well the person establishes and maintains personal relationships including those made at work and in the family settings as well as those that exist in other settings.

c) Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, sex and culture.

d) Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries.

e) Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, sex, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.

3. Duration - one or more of these conditions of duration shall apply:

a) Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two (2) years, or
b) The individual has been hospitalized for mental illness more than once in the last two (2) years, or
c) There is a history of one or more episodes with marked disability and the illness is expected to continue for a two year period of time.

Presentation of Severe Mental Illness

It is important to remember that individuals with a severe mental illness are not symptomatic all the time. If not entirely symptom free, they may have a low level of symptoms that are, at times, manageable. An important function of case managers is providing sufficient monitoring so that the client experiencing an episode of their mental illness can be referred to appropriate treatment as early as possible and hopefully prevent hospitalization. Therefore, it is important for case managers to have some awareness of, and knowledge about, the various types of serious mental illnesses that our clients may have, and be able to recognize symptoms. We will highlight several of the most prominent disorders but recommend that case managers become familiar with information found in the DSM-IV-TR.

Important: Case managers do not diagnose or provide mental health treatment. It is important to always consult with your supervisor and/or the client's clinician.

Psychotic Disorders

The common characteristics of these disorders are symptoms that center on problems of thinking.

Positive and Negative Symptoms - The DSM-IV-TR describes "positive" and "negative" symptoms:

> Positive symptoms represent the presence of something extra that people do not ordinarily experience. Hallucinations and delusions are examples of positive symptoms.
>
> Negative symptoms represent the absence of something that people ordinarily experience. For example, people with a psychotic disorder may experience affective flattening, social withdrawal, and decline in personal hygiene and grooming.

Delusions and Hallucinations - The most prominent (and problematic) symptoms are delusions and hallucinations.

> Delusions are false beliefs that significantly hinder a person's ability to function. For example, they may believe that people are trying to hurt them, or they may believe they are someone else (a CIA agent, God, Superman, etc.).
>
> Hallucinations are false perceptions. The most common hallucinations are auditory and are experienced by the client as "hearing voices." Other types include: olfactory (smelling), tactile (feeling sensations), taste, or visual (seeing things that are not there).

Other symptoms that may be experienced include: disorganized or illogical speech and disorganized behavior.

Types of Psychotic Disorders

Schizophrenia – This is one of the most common of the psychotic disorders and one of the most devastating in terms of the effect it has on a person's life. Symptoms may include the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, social withdrawal, lack of interest, and poor hygiene. The disorder has several specific types depending on what other symptoms the person experiences:

- Paranoid Type – There is a preoccupation with one or more delusions or frequent auditory hallucinations. These are often experienced as threatening

to the person. With this type, the person *does not* experience prominent symptoms of disorganized speech, behavior, flat or inappropriate affect.

- Disorganized Type – There is a prominence of all of the following: disorganized speech, disorganized behavior, flat or inappropriate affect.

- Undifferentiated Type – A type in which the major symptoms are present but criteria for paranoid, disorganized, or catatonic types are not present.

- Catatonic Type – Characterized by significant motor problems such as immobility, excessive motor activity, peculiarities of movement, or echolalia, and mutism.

- Residual Type – Absence of the prominent symptoms of schizophrenia but some continuing evidence of the disturbance as indicated by the presence of negative symptoms of two of the prominent symptoms in an attenuated form (odd beliefs, unusual perceptual experiences).

Schizoaffective Disorder **–** Another psychotic disorder in which symptoms that meet the criteria for schizophrenia are present and during which, at some time, there is either a Major Depressive Episode, or a Mixed (Manic) Episode concurrent with symptoms of schizophrenia.

Delusional Disorder **–** A psychotic disorder in which a person experiences a non bizarre delusion for at least one month. This type of delusion involves a situation that could occur in real life (for example, being followed or watched, poisoned, loved at a distance, or having a spouse that is cheating on them).

Other psychotic disorders include: Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder Not Otherwise Specified, Psychotic Disorder Due to a General Medical Condition, and Substance Induced Psychotic Disorder.

Mood Disorders

The disorders in this category include those where the primary symptom is a disturbance in mood, where there may be inappropriate, exaggerated, or a limited range of feelings or emotions. Everyone gets down sometimes, and everybody experiences a sense of excitement or emotional pleasure. When a client has a mood disorder, feelings or emotions are to the extreme. Many clients with mood disorders function very well in outpatient settings though they may be
hospitalized for brief periods.

Depression – Instead of just feeling down, the client might not be able to work or function at home, they might feel suicidal, lose their appetite, and feel very tired or fatigued. Other symptoms may include: loss of interest, weight changes, changes in

sleep and appetite, feelings of worthlessness, loss of concentration, recurrent thoughts of death.

Mania – This includes feelings that would be more towards the opposite extreme. There might be an excess of energy where sleep was not needed for days at a time. The client may be feeling "on top of the world," and during this time, the client's decision- making process might be significantly impaired and expansive, they may experience irritability and have aggressive outbursts, although the client might think they were perfectly rational.

Bipolar – A person with Bipolar disorder cycles between episodes of mania and depression. These episodes are characterized by a distinct period of abnormally elevated, expansive, or irritable mood.

Symptoms may include:

- inflated self-esteem or grandiosity
- decreased need for sleep
- more talkative than usual
- flight of ideas or a feeling that their thoughts are racing
- distractibility
- increase in goal-directed activity
- excessive involvement in pleasurable activities that have a high potential for painful consequences (i.e. sexual indiscretions, buying sprees)

Individuals who have recurring manic episodes will frequently have a problem keeping jobs or having stable relationships. Their behavior may get them into financial trouble or even result in criminal charges. When experiencing mania, the person will often have great difficulty making decisions that are in their best interest.

The depressive phase of this illness can also be quite devastating and if the depressive episode follows a manic episode, the contrast can be unbearable.
Individuals with bipolar disorder can experience severe depressive symptoms and may at times be a significant risk for suicide.

Personality Disorders

Individuals with Personality Disorders have symptoms and personality traits that are enduring and play a major role in most, if not all, aspects of the person's life. These individuals have personality traits that are inflexible and cause impairment in social or occupational functioning or cause personal distress. Symptoms are evident in their:

- thoughts (ways of looking at the world, thinking about self or others)
- emotions (appropriateness, intensity, and range)
- interpersonal functioning (relationships and interpersonal skills)
- impulse control

Personality disorders are listed in the DSM-IV-TR under three distinct areas, referred to as "clusters." The clusters are listed below with the types of symptoms or traits seen in that category and the specific personality disorders included in each cluster:

- Cluster A – Hallmark traits of this cluster involve *odd or eccentric behavior.* It includes: Paranoid, Schizoid, and Schizotypal Personality Disorders.

- Cluster B – Hallmark traits of this cluster involve *dramatic, emotional, or erratic behavior.* It includes: Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders.

- Cluster C – Hallmark traits of this cluster involve *anxious, fearful behavior.* It includes: Avoidant, Dependent, and Obsessive-Compulsive Personality Disorder.

Because of the way that individuals with Personality Disorders from Cluster B present, they are frequently referred for case management services. Many of these individuals have a dramatic presentation and exhibit a high level of use of services including hospitalization. It is important to do a careful needs assessment with these individuals to make sure they can benefit from case management services. It may be contraindicated to provide a long-term supportive service. However, they may benefit from short term targeted services such as: referrals to vocational programs, assistance with paperwork for entitlement programs, etc.

Personality Disorders offer a unique challenge. A thorough needs assessment and consulting with your supervisor is critical when providing services to individuals with Personality Disorders. For personality disorders that do not fit any of the specific disorders, the diagnosis of Personality Disorder NOS (not otherwise specified) is used.

Now that we have a better understanding of the presentation of certain diagnosis and how symptoms impact people's lives, in the next chapter we will look at case management practice and how case management can facilitate rehabilitation and recovery.

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DSM-VI-TR
ICD-9

UNIT 3

CASE MANAGEMENT PRACTICE

Description:

This unit presents the definition, models, levels, functions, and critical elements of case management. This unit also introduces the concept of recovery and the ingredients of a recovery oriented system of care.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Describe four case management models.
2. Describe three levels of case management.
3. Define intensive case management.
4. Identify functions of case management.
5. Identify critical elements of case management practice.

Models of Case Management Practice

Beginning in the early 1980's specific models of case management began being formulated and evaluated. The four dominant models are summarized below.

Broker Model: This model focuses on assessing the need of an individual for particular services, and identifying and ensuring availability of those services. The case manager serves primarily as a finder, rather than a provider of services. Linkage and coordination are the main functions of this model. The case manager invests a great deal of effort in establishing relationships with providers. (Rapp, 1995 and NCDMH/DD/SAS, 1994)

Strengths Model: This model minimizes illness and focuses on consumer strengths. Consumers are coached in setting their own goals and identifying realistic steps in order to achieve them. The model rests on two underlying assumptions about human behavior. The first is that people who are successful at living have the ability to use and develop their own potential, and have access to the resources needed to do this. The model identifies a person's strengths and actively pursues situations (environmental or personal) where success can be achieved and the level of personal strength enhanced. The second assumption is that human behavior is largely a function of the resources available to individuals, and that society values equal access to resources. Case managers assist consumers in securing resources in important life domains essential for human growth and development. A primary focus of this model is on securing environmental resources. The community is broadly conceived as a network of resources available to enrich the consumer's life. Rather than focusing on intervention and treatment for an "illness", this model aims to provide the environmental support needed to develop and move closer toward goals identified by the individual. (Rapp, 1995 and NCDMH/DD/SAS, 1994)

Rehabilitation Model: The consumer's goals and needs, rather than pre-established system goals, dictate the response and the form of case management services. It is a process of assisting consumers to become successful and satisfied in the social environment of their choice with the least amount of professional help. This is done by identifying the unique strengths and deficits of individual consumers and by teaching skills that will help them function in their chosen environments and reach their personally chosen goals. Recovery is a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. (NCDMH/DD/SAS,1994; Rapp, 1995; and Kartell & White, 1997)

Assertive Community Treatment Team (ACTT) Model: This model uses an actively involved team approach to assist consumers to make improvements in their level of functioning in the community. It includes: an interdisciplinary team responsible for a fixed group of consumers; assertive outreach; community-based services ("in vivo" treatment in the community); individualized and ongoing treatment. An urban team usually consists of eight to twelve team members serving no more than 120 consumers and a rural team usually consists of five to seven team members serving no more than

80 consumers. This approach combines the traditional functions of case management with supportive psychotherapy, symptom management, and crisis intervention. Case managers not only broker services, but provide treatment as well. (Rapp, 1995; Kartell & White, 1997)

Model Summary

In the 1980's, after a careful review of models, Kentucky chose to use the Strengths Model as a base for case management service provision. While we continue to train case managers in the Strengths Model, we will begin to blend elements of the Psychiatric Rehabilitation model of case management into this training recognizing this model as a best practice in services for persons with SMI.

Levels of Case Management Practice

Level I CM	**Level II CM**	**Level III CM**
most intensive - available 24/7	available 24/7 but uses on-call for crisis intervention	least intensive - available regular 40 hr week with on-call for crisis intervention
directly providing frequent and comprehensive CM support	goal directed CM and is recovery and outcome oriented	recovery and outcome oriented
for the most severely disabled adults focusing on stability of symptoms	for people who wish to make regular progress in growth and rehabilitation	for those satisfied with their role or are able to self manage much of their progress
maximum caseload: 13 persons	maximum caseload: 20-25 persons	usual caseload: 60-80 persons
usually practiced in teams, including one FT/PT nurse or psychiatrist	may be practiced in teams or individually with team support	usually individual practice with team support
always community-based practice	mostly community-based practice	largely office-based practice
average of 4 contacts per week	average of 4-11 contacts per month	average 4 face-to-face and 8 phone contacts per year

Level I CM	Level II CM	Level III CM
increased community tenure	increased community tenure	consumer satisfaction with personal life domains
reductions in the frequency or length of crisis or hospital services	decreased crisis episodes and increase in time spent working or in school	continued stability as measured by no hospitalizations
decrease in symptoms and side effects	increased social contacts, personal satisfaction and independence	continued decrease in frequency and duration of crisis episodes
increased social integration, housing stability	independent or semi-independent living arrangements	increased personal independence in any life domain
reduced impairment from substance abuse	reduced impairment from substance abuse	sustained recovery from substance abuse
decrease in level of care needed or desired	consumer satisfaction	
consumer satisfaction		

Definition of Case Management

There are many recognized definitions for Case Management. There is, however, a lack of consistency and clarity among the definitions which continues to present problems in operationalizing the service. Most of the existing definitions are so broad that almost anything a practitioner does may be described as case management. This leads to a significant source of confusion and misunderstanding is the various uses to which the term "case management" is applied.

The guidelines in this manual are intended to be applied to a modality of service that has been labeled intensive case management. This is a specialized community support service that has been developed within the Kentucky Cabinet for Health and Family Services, Department of Medicaid Services and Division of Mental Health to meet the needs of a specific subgroup of people who have a severe and persistent mental illness.

The National Association of Case Management's (NACM) Definition of Case Management is:

> *"CM is a practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of the individual's personal goals for community living." (Hodge & Giesler, 1997)*

This definition suggests that the **functions of CM** are:

- Obtaining basic supports
- Crisis prevention and intervention
- Assessment to determine needed services and resources
- Outcome focused service/treatment planning
- Referral and linkage with chosen services
- Engagement and developing a helpful, trusting relationship
- Coordinating and adjusting service delivery
- Advocacy

Critical Elements of Case Management Practice

The critical elements of case management have become the method by which both functions and values are operationalized in CM practice. These are important features of CM that must exist regardless of model or level of intensity. These critical elements for the practice of CM include:

1. The emphasis is on intervention in the consumer's natural environment rather than an artificially created environment;

2. The intervention is comprehensive and connotes a whole person (holistic) focus rather than being fragmented by agency demands;

3. The intervention is accentuated by aggressive engagement, follow-up and frequent contact that is based on consumer need rather than agency dictates;

4. Case management focuses on strengths, skills and supports and minimizes weaknesses, but does not overlook them;

5. Case management presumes active consumer involvement as a partner with the case manager in planning and implementing services;

6. The direction of the intervention is based on consumer choice and control of his/her destiny;

7. The case management intervention assumes responsibility for integration of significant others, if the consumer wishes, into the planning, execution and achievement of goals the consumer has set;

8. The case manager reduces involvement commensurate with the consumer's ability to plan for his/her own needs, yet remains sensitive to fluctuations in that ability.

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UNIT 4

A RECOVERY- ORIENTED SERVICE SYSTEM

Description:

This unit will review the concept of “recovery” as it applies to people with severe mental illness. We will review definitions of recovery in the literature, and the framework of a recovery-oriented service system.

Objectives:

1. Define recovery.
2. Recognize assumptions about recovery.
3. Describe the four key concepts in recovery.
4. Describe a recovery-oriented system of care.

Recovery

One of the important concepts in the field of mental health is the idea that people can recover from a mental illness, even the most severe mental illnesses. Just as there are many definitions of case management, there are perhaps more definitions of recovery. By recovery, we mean that the consumer is able to regain social roles and identities that are identified as valid by the consumer and the people in their community. It also means regaining rights and taking personal responsibility.

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, **recovery is the ability to live a fulfilling and productive life despite a disability.** For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having **hope** plays an integral role in an individual's recovery.

Recovery Definitions

William A. Anthony, PH.D, Executive Director at the Center for Psychiatric Rehabilitation defines recovery as:

> **Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.**

The Ohio Department of Mental Health defines recovery as:

> **Recovery is a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.**

Molly Clouse, Peer Consultant for the Kentucky Division of Mental Health defines recovery as:

> **A process of regaining one's life to a usable form; to reclaim one's personal power from one's illness.**

The President's New Freedom Commission on Mental Health reports a recovery oriented vision as;

> **"A future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community."**

Recovery-Oriented Service System

A recovery vision of service is grounded in the idea that people can recover from mental illness and that the service delivery system must be constructed based on this knowledge. In the 1980s, two events ushered the concept of recovery from mental illness into the 1990s (Anthony, 2000). These were the large number of consumers who were writing about their own recovery and the empirical work in the 1980s of Harding and her associates. Prior to these two "events" the belief was that severe mental illness, particularly schizophrenia, was a deteriorative disease (American Psychiatric Association, 1980). Therefore, mental health systems and programs were built around the belief that people with SMI "did not recover, and that the course of their illness was essentially a deteriorative course, or at best a maintenance course" (Anthony, 2000).

However, after deinstitutionalization, Courtenay Harding and her colleagues followed a number of long-term research studies that showed that one's actual mental illness had less to do with one's chronicity than the "myriad of environmental and other social factors interacting with the person and the illness" (Harding, Zubin, & Strauss,1987, p.483). This new concept was supported by a growing body of consumer literature that was woven together with personal accounts of recovery. In 1987, the idea that people can recover from mental illnesses was made official with the publication of the DSM III-R (Anthony, 2000).

As the concept that people with severe mental illnesses can and do recover filtered through mental health systems, so did a variety of concepts about what recovery looked like and how it was to be achieved and by whom. In looking at recovery and how our current system of mental health services support recovery, we will review assumptions about recovery, identify essential services included in a recovery oriented service system, and list key characteristics of a recovery oriented service system.

Assumptions about Recovery

- Recovery can occur without professional intervention.
- A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.
- A recovery vision is not a function of one's theory about the causes of mental illness.
- Recovery can occur though symptoms reoccur.
- Recovery is a unique process.
- Recovery demands that a person has choices.
- Recovery from the consequences of the illness is sometimes more difficult than the illness itself.

Essential Services of a Recovery-Oriented Service System

Treatment –	Symptom relief
Crisis Intervention –	Personal safety assured
Case Management –	**Services accessed**
Rehabilitation –	Role functioning
Enrichment –	Self-development
Rights protection -	Equal opportunity
Basic Support –	Personal survival assured
Self-Help –	Empowerment
Wellness/Prevention –	Health status improved

Characteristics of a Recovery-Oriented Service System

- The mission of the organization includes a recovery vision that drives services.
- A core set of needed services are identified.
- Consumer and family member satisfaction is measured and important.
- Leadership constantly reinforces the recovery vision.
- Written policies encourage programs to be recovery friendly.
- Service staff is assigned based on competencies and preferences.
- Case Management services are available to consumers who want or need it.
- Consumer goals include functioning in living, learning, working, and/or social environments.
- Consumers are actively sought for employment at all levels of the organization.
- Self-help services are available in all geographic areas.
- Consumers and family members are actively involved in designing services and evaluation.
- Policies insure that the knowledge, skills, and attitude of staff enable them to provide effective, culturally competent care.
- Policies insure that all levels of staff understand the recovery vision and how it impacts services.
- Funds are designated based on consumers' expressed needs.
- Funds are designated based on expected outcomes of services.
- Access to services is based on consumer preference rather than professional preference.
- Access to services does not depend on using a particular mental health service.
- Access to living, learning, working, and social environments outside the mental health system is expected.

Key Concepts in Recovery

- **Hope** – Consumers need to feel they can get better and have a good life.

- **Personal Responsibility** – Consumers need to feel they can control their own lives and take responsibility for their own care.

- **Education** – Consumers need information about their illness and treatment options.

- **Self-Advocacy** – Consumers need support from others, including family, peers, professionals, and the community.

Recovery often depends on the consumer finding someone who believes in him or her. When a case manager is able to take that type of supportive and encouraging role with a consumer, it is very powerful and can be instrumental in that consumer's success.

UNIT 5

KENTUCKY CASE MANAGEMENT
REHABILITATION AND RECOVERY MODEL

Description:

This unit will provide an overview of the values and principles that drive and energize case management practice reviewing both the Strengths Model and the Psychiatric Rehabilitation Model. Major activities of the case management process will also be presented and illustrated.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Describe the values and principles of the Strengths Model of Case Management.
2. Describe the values and principles of Psychiatric Rehabilitation.
3. Describe the four major activities in the case management process.

The Kentucky Case Management Model of Rehabilitation and Recovery

The Kentucky Case Management Model of Rehabilitation and Recovery evolved from the University of Kansas Developmental-Acquisition Strengths Model of Case Management. In efforts to continue to move towards a recovery-oriented model of case management, the Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) blended concepts of strengths, rehabilitation, and recovery resulting in the Kentucky Case Management Model of Rehabilitation and Recovery as outlined in this chapter.

Key Values of the Strengths Model of Case Management

The Strengths Model of Case Management assumes that people have strengths, goals, and dreams. The community is viewed as an oasis of resources. Meaningful relationships and access to resources are essential to attaining personal goals. This model values consumer choice, self determination and empowerment. It recognizes the power of the consumer-case manager relationship as a partnership. The model also values assertive outreach and group supervision as effective tools in facilitating personal growth and change.

Principles of the Strengths Model of Case Management

1. The focus is on individual strengths rather than pathology.

2. The case manager-client relationship is primary and essential in the facilitation of growth and change.

3. Interventions are based on the principle of client self determination.

4. Aggressive outreach is the preferred mode of intervention.

5. Resource acquisition activities are used to acquire environmental resources.

6. Group supervision is used to monitor client progress and foster creativity among case managers.

7. The community is viewed as a resource and not as an obstacle to service delivery.

8. Persons suffering from severe mental illness have the ability to learn, grow and change.

Key Rehabilitation Values

Person Orientation:	A focus on the human being as a whole, rather than as a diagnostic label or illness.
Functioning:	A focus on performance of everyday activities.
Support:	A focus on providing assistance for as long as it is needed and wanted.
Environmental specificity:	A focus on the specific context of where a person lives, learns, socializes, or works.
Involvement:	A focus on including individuals as full partners in all aspects of rehabilitation.
Choice:	A focus on the person's preferences throughout the process.
Outcome orientation:	A focus on evaluating rehabilitation in terms of the impact on client's outcomes.
Growth potential:	A focus on improvement in a person's success and personal satisfaction, regardless of the person's current difficulties.

Nine Principles of Psychiatric Rehabilitation

1. A primary focus of psychiatric rehabilitation (PR) is on improving the capabilities and competencies of persons with psychiatric disabilities.

2. The benefits of PR for the clients are behavioral improvements in their environment of need.

3. Supporting dependency can lead to an eventual increase in independent functioning.

4. The two fundamental interventions of PR are the development of skills and the development of environmental supports.

5. The focus of PR is on improving residential, educational, and vocational outcome for persons with psychiatric disabilities.

6. Active participation and involvement of individuals in their rehabilitation process is the cornerstone of PR.

7. Long-term drug treatment is an often necessary but rarely sufficient complement to a rehabilitation intervention.

8. Psychiatric rehabilitation is eclectic in the use of a variety of techniques.

9. Hope is an essential ingredient of the rehabilitation process.

Major Activities of the Case Management Process

Case management can be thought of in terms of the following four major activities:

1. **Coordinating** with and for the client

    - Develop a long-term supportive relationship with the clients.
    - Maintain regular contact with clients ranging from several times a day to once a month contact, depending upon client needs.
    - Maintain contact with eligible clients no matter where they reside (i.e., homeless, hospital, jail, group home, own apartment, etc.) through *outreach*, taking the initiative to stay in touch.
    - Provide case management services to eligible clients on a continuous basis, depending on the clients' needs.
    - Discuss and develop a comprehensive service plan for and with each client based upon a needs assessment.

2. **Advocating** for client rights

    - Work with clients to advocate for service improvements when services are judged unfair, inadequate or non-existent.
    - Assist clients in using formal grievance processes, starting at the local level and culminating with the state Cabinet for Health and Family Services ombudsman or Division of Protection and Advocacy, if necessary.
    - Bring examples of unmet needs, and possible solutions for meeting such needs, to the attention of mental health decision-makers for their consideration for possible action.
    - Encourage and assist clients to join any advocacy groups in their area or form groups where none exist.

3. **Linking** to services

- Become knowledgeable about the community supports and resources available to clients (i.e., public and private treatment providers, advocacy and self-help groups, low-income housing resources, employment and training programs, financial benefits, etc.) Maintain regular contact with these groups to aid client access.

- Work with clients to:
  ⇒ access appropriate treatment programs within local resources
  ⇒ obtain all benefits for which they are eligible
  ⇒ obtain a satisfactory living situation
  ⇒ secure employment training and/or work opportunities and assist them in meeting employment goals
  ⇒ obtain needed health care services as well as regularly scheduled physical examinations

- Assist clients in developing a range of social supports (i.e., client self-help groups, families, peers, etc.)

- Encourage family members to get involved with organizations such as the National Alliance for the Mentally Ill (NAMI), local affiliates and/or family support groups.

- Assist family members in accessing mental health and social services programs to meet their own needs.

4. **Monitoring**

- Follow-up and evaluate, with the client, to ensure that services are meeting their needs.

- Evaluate services, with the client, on an on-going basis to assess if the client can reach the goals of their service plan.

Each of these critical functions will be examined in the upcoming units.

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UNIT 6

COORDINATING WITH AND FOR CLIENTS

Description:

This unit will outline the importance of the case manager – consumer relationship including the elements of relationship, boundary issues, and NACM ethical guidelines. This unit will also introduce consumer rights and discuss confidentiality issues and principles.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Describe the essential elements of a case manager-consumer relationship.
2. Discuss boundary issues and NACM ethical guidelines.
3. Describe general client rights issues.
4. Articulate the philosophy behind the Assurance of Case Management Services Certification Form.
5. Explain confidentiality issues and principles.

Case Manager – Consumer Relationship

A primary factor in being a successful case manager is the working relationship. A good case management relationship is based upon trust, mutual respect and a willingness to work together to attain agreed-upon objectives. The primary target for change is not the individual, but the environment.

The case manager does not attempt to change the client's beliefs, values or emotions, but works with the client to improve living conditions. In doing this, the case manager can help the client increase his/her skills, and expand the individual's horizons. A strong partnership for advocacy, when it is conscientiously pursued over the long term, can change people as well as their environment. The case management relationship, like any other, thrives on consistency, regularity of contact, openness, honesty and the careful building of trust.

Engaging and Connecting

The case manager's ability to engage and connect with the client is very critical in developing the consumer-case manager relationship. Developing and establishing trusting relationships is an ongoing process and requires a variety of skills.

Case managers must develop a belief in the potential for growth in the clients which they serve. Your attitude about severe mental illness, the people who are diagnosed as having a severe mental illness, and the possibility of change are communicated to the person seeking help. You are attempting to form a partnership with the individual, be aware that your actions will influence the development of this partnership. You are a vital participant in the change process and must convey a positive, open perspective if you are to have any impact.

Case managers must be timely, reliable, dependable, and authentic in all their interactions with clients. Different clients may want to have different degrees of personal connections with their case managers. Some may find frequent contacts intrusive; others may need daily support.

Some critical elements of engagement:

- Start slow; do not push the client to make decisions about services.
- Do not assume that the client will know what you mean by case management services, or that they will desire this type of service. The best way to describe what case management is all about is by doing.
- A few days after the initial contact, follow-up contact either by phone or by home visit is essential.
- If the client does not contact you on the agreed upon date, it is your responsibility to reinitiate contact and set a time when you can both get together.
- Use the assessment, which will be described in Unit 7, as a tool to build a partnership with the individual.

- If you are unable to arrange for the individual to meet with you, try to establish an alliance with a significant other (family member, friend, or relative) in the client's life. It is critical that this be accomplished in keeping with the confines of confidentiality.
- Finally, be willing to talk openly and honestly with the client about their illness.

The process of change is slow and will not always progress as you would like. You ultimately are the key, be patient and communicate your willingness to struggle with the client as they attempt to adjust. Remember, establishing relationships takes time.

Boundary Issues and Ethical Guidelines

Case managers need to be conscientious about providing services within local, state and federal laws, as well as general ethical practices. Issues of concern may include substance abuse, confidentiality, dual relationships, setting and maintaining appropriate boundaries, and imposing own values. Case managers are continually challenged with boundary issues. The very nature of the service opens it up to scrutiny. As case managers continue to redefine and reassess what is professional and nonprofessional behavior in their practice, it is understood that there is a thin line between the two.

As case managers, you will be faced with boundary and ethics issues on a daily basis. The following information is designed to assist you in making critical decisions concerning these issues. There are not any definitive measures or directives, but there are guidelines and strategies that will facilitate daily practice.

The boundaries established by staff are based on many factors, including, board policies, program/service expectations, past experiences, and personal comfort. Most limits and boundaries are maintained by sound judgment of the case manager.

There are a variety of ways to define a boundary. What is important in the helping relationship is that:

- You know your own boundaries and are honest about them; and
- You respect those of the consumers with whom you work.

What should you do when faced with a situation where boundary issues may be a concern? Ask yourself:

- What is my intended action?
- What is my intended effect on the consumer?
- What are other possible effects on the consumer, positive and negative?
- What promises might this action imply? (Could this be misunderstood?)
- Does this action change any roles?
- For whom am I doing this; whose needs am I meeting?
- Are there other ways or actions to reach my intended goal?

Case managers must never under any circumstances, date or in any way encourage intimacy with clients. They should not routinely receive phone calls at their homes or otherwise indirectly suggest that the professional relationship may become a personal one. Supervisors and other staff members should be used to help the case manager answer specific questions about this.

Case managers who were previously, or may still be clients, may have special problems in clarifying which role is appropriate. The client case manager can have special understanding and sympathy for the problems of clients, but that very strength might sometimes result in conflicting loyalties and misunderstandings. The client case manager needs to discuss these problems with his/her supervisor and know the specific expectations of the agency.

The following ethical guidelines by the National Association of Case Management (NACM) should be studied and understood by each case manager:

As a Case Manager, I:

- √ Am committed to respect the dignity and autonomy of all persons and to behave in a manner that communicates this respect.
- √ Am committed to each individual's right to self-determination, and the rights of people to make their own life choices, and I am committed to embarking hopefully on a recovery journey with every person I serve, letting them direct their own healing process.
- √ Am committed to fight stigma wherever I find it, to educate the community, and to promote community integration for the people I serve.
- √ Do not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, creed, gender or sexual orientation.
- √ Strive to both seek and provide culturally sensitive services for each person and to continually increase my cultural competence.
- √ Am committed to helping persons find or acknowledge their strengths and to use these strengths in their journey of recovery.
- √ Am committed to helping persons achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills and competencies.
- √ Acknowledge the power of self-help and peer support and encourage participation in these activities with those I serve.
- √ Am honest with myself, my colleagues, the people I serve, and others involved in their care.
- √ Keep confidential all information entrusted to me by those I serve except when to do so puts the person or others at grave risk. I am obligated to explain the limits of confidentiality to the persons I serve at the beginning of our working together.
- √ Am committed to a holistic perspective, seeing each person I serve in the context of their family, friends, other significant people in their lives, their community, and their culture, and working within the context of this natural support system.

- √ Must strive to maintain healthy relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.
- √ Maintain a commitment to prevent crisis situations with the people I serve, to present and support crisis alternatives, to develop an advanced instruction crisis plan with the individual whenever possible, and to avoid forced treatment unless there is a clear and present danger to the person served or another.
- √ Have an obligation to consult with my supervisor, obtain training, or refer to a more qualified case manager any individual with a need I do not feel capable of addressing.
- √ Have an obligation to remain curious; learning, growing, developing, and using opportunities for continuing education in my field or profession.
- √ Am committed to a regular assessment of my service recipients' expectations of me and to consistently improving my practice to meet their expectations.
- √ Have an obligation to advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs.
- √ Am obligated to learn the laws and regulations governing my practice and to abide by them, including the duty to warn anyone in danger of physical harm, and the duty to report physical, sexual, emotional and/or verbal abuse to the proper person or agency.
- √ Am obligated to work supportively with my colleagues and to keep their confidences.
- √ Am obligated to urge any colleague who appears impaired to seek help and, failing this, to discuss my concerns with the appropriate agency authority.

Clients Rights

Consumers in state-operated and private facilities and agencies have certain rights, including the right to dignity, privacy, humane care, and freedom from abuse. They also have the right to treatment, the right to be informed of risks and benefits of treatment, the right to an individualized treatment plan, and the right to be free from unnecessary or excessive medication. Consumers have the right to refuse medication during involuntary inpatient or outpatient commitment or voluntary inpatient commitment. However, in certain circumstances--and following prescribed procedures--consumers may be given medications against their wishes in an inpatient setting.

It is imperative for case managers to understand the rights of consumers, laws established concerning consumer rights, and agency policies and procedures regarding consumer rights and responsibilities. These should be discussed in supervision.

The **Kentucky Department for Medicaid Services** identifies **five basic client rights** in the Targeted Case Management Services Adults Manual:

1) Clients shall have freedom of choice of case management services.

2) Clients shall have freedom of choice of participating case management providers.

3) Clients shall have freedom of choice of case managers employed by the case management provider.

4) Clients shall be allowed to have free choice of service providers of any other Medicaid-covered services.

5) Clients shall be involved in the development of their treatment plans.

Assurance of Case Management Services Certification Form (MAP-586) shall be signed by the client and placed in the client's record.

Confidentiality

Confidentiality is very important to the case manager-client relationship. Case managers must be informed about confidentiality laws, and agency policies and procedures regarding the disclosure of information. What is confidential information? It is any information related to an individual served by an agency or facility that was received while the agency or facility was providing any function for the person. Confidentiality is both a clients' rights issue and a professional ethics issue. It is a necessary ingredient in the case manager-client relationship.

There may be instances when it is helpful to share client information with others who provide assistance to the consumer, including family and friends. To prevent any problems with sharing information when it is necessary, the case manager and the client must consider situations that may warrant this and appropriately plan for them.

Although maintaining confidentiality is a necessary ingredient for the case manager-client relationship, open and honest communication to the client about the limitations of complete confidentiality is critical. There are a variety of situations where it is ethical and legal to compromise confidentiality. Therefore, confidentiality is not an absolute. Exceptions to the confidentiality rule are as follows:

- Client is a danger to himself and/or others;

- Abuse, neglect, or exploitation of children or adults;

- It is necessary to honor the duty to warn laws; and

- Third party payer sources request access to client records.

Case managers must be careful to not share unnecessary information with others about the client in their efforts to provide assistance and access resources. Client rights and confidentiality must be respected at all times. Case managers should always consult with supervisors regarding confidentiality questions or issues.

Sources (See Bibliography in Appendix I):

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UNIT 7

PLANNING FOR SERVICES
ASSESSMENT: STRENGTHS, NEEDS, AND PRIORITIES

Description:

This unit describes the assessment phase of the case management process focusing on how to assess client strengths, needs and priorities. This unit also addresses the culturally competent practitioner. A case example is provided to demonstrate the implementation of a case management strengths assessment.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Understand the concept of multiculturalism and the need for culturally competent practice.

2. Explain the difference between a strengths assessment and a diagnostic assessment.

3. Describe the process to complete a case management strengths assessment.

4. Complete a case management strengths assessment.

Overview

Unit 7 will describe assessment, identification of needs, and prioritization of needs. It is imperative that these steps be seen as interchangeable. Do not approach the assessment process, identification of needs, or the prioritization of needs in a rigid and technical manner. The individual coming for services is not someone to be processed in a routine manner. Unique individual characteristics, values, desires and needs must be taken into consideration. Remember that each step of the model represents a building block for change and the enhancement of growth for the clients that you serve. Again, be patient, attend to the person in front of you, and most of all be willing to move in tandem with the client as the process evolves.

Multiculturalism

The multicultural principles adopted by the International Association of Psychosocial Rehabilitation Services (IAPSRS) provide a framework for understanding the interaction of culture and mental health, as well as the practitioner's responsibility to continually strive toward a multicultural practice. The following are the key concepts of multiculturalism:

- Multiculturalism is the study of one's own culture and ethnicity as the basis for the understanding and identifying with those of others
- Everyone has a culture, not just those whom we think of as minorities
- Everyone has an ethnicity, therefore every human encounter is a cross cultural encounter
- Our society is viewed as a mosaic rather than a melting pot
- All behavior occurs within a cultural context and we apply our own "cultural lens" to view the behavior of others
- Multiculturalism denotes the full inclusion of the individual with his or her culture and differences
- Multicultural professionals are students of their own ethnicities and cultures, and are aware of their own and other's biases, stereotypes and prejudices

The challenge is to respond to differences rather than to minimize them. The reality is that each of us has grown up in an encapsulated environment that has provided our value base, ethnic base, perceptions of family, and what is viewed as being right or wrong. Thus, in approaching others who may be different, many operate from their own ethnocentric perspective, which they treat as the only correct one. The reality is that one's own way is not always the right way for all people. It may mean that after developing self-awareness, one will have to change the way one works with differences so as to be effective in rendering relevant services that are culturally respectful of consumers.

Eleven Principles of Multiculturalism (IAPSRS, 1996)

Principle One: Practitioners accept that every individual has an ethnicity, as well as a gender, sexual orientation, level of ability/disability, age and socioeconomic status; therefore, they view every human encounter as a cross-cultural encounter.

Principle Two: Practitioners study, understand, accept, and appreciate their own cultures as a basis for relating to the cultures of others.

Principle Three: Practitioners recognize that differences, discrimination, and isolation continue to create unique situations in which culture may emerge. The cultures of gender, disability, or sexual orientation may also provide support, security, a sense of belonging and identity, similar to the cultures of ethnic heritage. The conditions of stigmatization, rejection, and discrimination are addressed as rights violations as well as barriers to the attainment of health.

Principle Four: Practitioners recognize that thought patterns and our behaviors are influenced by one's world view, of which there are many. Each world view is valid and influences how clients perceive and define problems, perceive and judge the nature of help given and solutions developed.

Principle Five: Professionals show respect towards clients by accepting cultural preferences which value process or product, as well as harmony or achievement, within one's life. Practitioners also demonstrate respect by appreciating cultural preferences, which value relationships and interdependence, in addition to individuation and independence.

Principle Six: Practitioners accept that the solution of problems is to be sought within consumers, their families, and their cultures. Alternatives identified by practitioners are to be offered as supplementary or educational.

Principle Seven: Practitioners apply the strengths/wellness approach to all cultures.

Principle Eight: Interventions are culturally syntonic (in emotional equilibrium and responsive to the environment) and accommodate culturally determined needs, beliefs, and behaviors. Modalities are modified in order to be compatible with family/group patterns and structures; communication, cognitive, behavioral, and learning styles; identity development; perceptions of illness; and help-seeking behaviors.

Principle Nine: Practitioners recognize that discrimination and oppression exists within our society; these take many forms, including race, ethnicity, gender, sexual orientation, class, disability, age, and religious discrimination/oppression. Practitioners have a role and responsibility in mitigating the effects of these "isms," advocating not only for access to the opportunity and resource structure, but for the elimination of all "isms."

Principle Ten: Practitioners are responsible for actively promoting positive inter-group relations, particularly between the consumers in their programs and the larger community.

Principle Eleven: Practitioners engage in ongoing cultural competence training in order to increase their knowledge and skills of appropriate effective cross-cultural interventions. Practitioners are committed to learning about problems and issues that adversely and disproportionately affect the various cultural groups with whom they work.

Planning for Services: The Assessment Process

In order to determine what services the client needs, an evaluation is necessary. This evaluation is called a needs/strengths assessment. Once this assessment is made, a service plan is developed which outlines long-term goals and the smaller steps that must be taken to achieve those goals.

The assessment reviews needs and strengths. All people have needs and deficits however a focus on strengths will provide the capability to address needs in a positive and motivating way. Throughout the manual the assessment will be referred to as a strengths assessment.

Assessment of Strengths

Assessment based on strengths is different from a diagnostic interview. Most diagnostic interviews focus on problems or deficits that the individual brings to the treatment process. These could include: 1) the individual is withdrawn; 2) hearing voices; and 3) is not taking the prescribed medication properly. In most cases the focus of the intervention would be to correct these problems. If the individual does not respond or is uncooperative with the prescribed treatment strategy, then the individual is labeled as "having a poor prognosis," "resistive," or "non-compliant." The assumption operating is that the professional is the expert who knows what is best and the individual is the recipient of services to be provided.

This process, based on a person's strengths, is intended to provide a framework from which the case manager and the client can view the client in positive, growth oriented terms. The degree to which the client is committed or motivated to work with the case manager corresponds directly to the degree to which they are involved in assessing or planning from the beginning.

The assessment should reflect the client's perspective, incorporating their strengths, likes and hopes in each part of the assessment process. It is important that the case manager assess with the client, not for the client, in order to facilitate a working partnership in the CM process.

What is a Strengths Assessment?

- A tool to obtain and represent the ongoing strengths and needs of the client.

- An assessment of the person's situation and circumstances include:

  - ⇒ behaviors indicating danger to self/others
  - ⇒ daily living skills (ADL's)
  - ⇒ interpersonal/social relationships
  - ⇒ mental health and substance abuse services
  - ⇒ vocational
  - ⇒ treatment participation
  - ⇒ medication compliance
  - ⇒ benefits/financial resources
  - ⇒ crisis incidents
  - ⇒ housing
  - ⇒ medical/health needs
  - ⇒ educational
  - ⇒ legal issues
  - ⇒ transportation

- The following questions may help guide the assessment process when meeting with the client:

  - ⇒ What kind of experience has the client had up to this time?
  - ⇒ What is going on now for the client?
  - ⇒ Where would the client like to be?
  - ⇒ What resources can he/she use to make the desired changes?
  - ⇒ What talents or experience can the client use to meet the desired goals?
  - ⇒ What steps does he/she need to take to make the changes?
  - ⇒ What is the most important at this time?

- The assessment is an ongoing working document and is to be updated when the client's status is altered, goals change, or new resources are acquired.

- This assessment is to be reviewed at least every 90 days.

Developing a Strengths Assessment

There are main areas that should be incorporated into the case management strengths assessment. These will include assessing and documenting the client's need for community resources and services. Assessment and services should build upon the assets, strengths, and capacities of clients in order to help them maintain a sense of identity, dignity and self-esteem. The procedure should be natural and flexible.

Some important principles that apply to all areas are:

- Start where the client is. An adult-to-adult relationship accentuates and models effective communication.
- Focus on strengths.

- Select a comfortable environment to conduct the assessment.

- All of the areas should be addressed and prioritized, as per the client's ability to participate.

- Ask open-ended questions.

- Involve family members and other significant social resources and natural supports in the process with the client's release of information.

Introduction and Exploration - In this initial phase, the case manager will:

- introduce himself/herself to the client

- explain the case management process and the goals of this service

- begin to evaluate the client's current level of engagement. It should be kept in mind that willingness to participate in case management services is closely associated with client choice. Persons may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals and objectives. Willingness must be cautiously evaluated by case managers and must not be used as an excuse for under-serving the client.

- explore the client's community and unique situation with respect to present and future needs, past experiences, interests, aspirations and current or previously used skills and resources.

Empowerment and Acceptance - The client is the "expert" about their own unique strengths, interests, and aspirations. Case managers can positively influence willingness by fostering hope and belief in the person receiving services. Services and strength assessments should incorporate client self-help approaches, and should be provided in a manner that allows clients to retain the greatest possible control over their own lives. As much as possible, clients set their own goals, decide what services they will receive and are active participants in the assessment, service plan development and the services provided.

This principle allows the client to share in the recovery process to the greatest extent possible. Active listening, reflection and verbal support are critical to the acceptance and empowerment of the client. In this process the case manager may respond to the information presented by the client

by restating what he/she has heard the client say. The client is encouraged to explore their situation to identify their own personal strengths. For example, “You said you'd like to live in an apartment; tell me what kinds of things you can do to live on your own."

The Strengths Assessment Discussion - The case manager responds to the client by moving in whatever sequence is natural throughout the discussion. It could begin with living arrangements and then move to finances. There is no prescribed sequence. The responses of the client are used to determine their level of need in the needs assessment. It is important to collect and record details regarding client responses. This information can then be incorporated into the strengths assessment.

Since a strengths assessment is ongoing, the case manager may stop the process at any point in order to:

- respond to a client’s restlessness or unwillingness to continue
- to start the prioritization of needs to move into the development of a service plan
- to set a continuation date/time to gather further information prior to developing service plan

Prioritizing Needs - After completing the strengths assessment, the dient and case manager must identify which areas should be chosen as priorities for goal setting. These are first based on critical survival needs (food, shelter, clothing, and medical care) and then less critical needs. Once the needs have been prioritized, the client and case manager are ready to develop a service plan to accomplish one or more of the goals.

Elements of the Case Management Strengths Assessment Form

The four page Case Management Assessment form is divided into three sections: Basic Information; Strengths Assessment; and Needs/Priorities.

Basic Information Section
This section of the Case Management Strengths Assessment will enable the consumer and case manager to obtain basic information on: identifying information; marital status; education status; sources of monthly income; monthly expenses; insurance coverage; and legal status.

Strengths Assessment
The second section is the actual Strengths Assessment. This section is the heart and soul of the strengths assessment process. When used creatively it serves as a tool to assist clients in developing an awareness

of their own strengths and potential. Information from the assessment sets the basis for subsequent steps such as establishing goals and hope. The strengths assessment is designed as a provocative document; it is not just a form to complete but provides questions to assist the client in looking at their current situation, their past and where they want to be in the future.

The Categories listed across the top of the strengths assessment form include:

Current Status: *"What's going on now?"*
Resources includes community as well as individual strengths such as SSI, SSDI, who lives with the person, attending GED classes, toward a GED, receiving medication, taking care of a pet, going for walks, belonging to a support group, etc. We frame these resources in a positive way. We do note all resources that can be defined. For example, it is strength if there is family contact. It is important to collect details about client responses. Frequency of activities or resources used, and type of use are important. For example, if a client says their favorite leisure time activity is playing basketball, then the case manger needs to find out: 1) if it is in league or with others or if it is shooting baskets by himself or herself; 2) does s/he play daily or once a month; and 3) how long has the person been doing this activity.

Personal Goals: *"Where I'd like to be?"*
Interests and aspirations are, perhaps, the most valuable strengths to be assessed. If the client is able to make "I want to..." statements, it is strength. If the goal appears unrealistic, the first steps toward attainment usually are not. For example, if the aspiration is to be employed, marketable work skills and experience are logical steps toward attainment of that goal.

Resources Internal/External: *"What have I used?" "What can I use?"*
Resources define areas of strengths to which the client has access, but which are not currently being used such as, work skills used in the past; membership in a club even though there is no attendance; old friends who have not been seen for some time; ability to cook even though the person is not now cooking; activities enjoyed in the past even though they do not seem of interest at the present time, etc. Again, we do not note what is wrong with any of the accessible resources. They are strengths on which to build. It is not the resource itself that is a strength. It is the individual's willingness and ability to be involved with it that is the strength.

Needs: *"What steps do I take to get there?"*
Initial needs for community living and the development of potential are assessed and noted in this column. This is not intended to be a formal

goal statement or resource acquisition plan. Readily identifiable needs to attaining ambitions and resources are noted. Examples of needs which may be noted in this section are: transportation to town, a current membership to the YMCA, an appointment for therapy, paints and brushes, a guitar, or fabric for quilting.

When the consumer and case manager work together to complete the current status and personal goals columns, a good strengths assessment is done. When they complete the resources and prioritized needs columns, the foundation for a good consumer-driven Service Plan will be built.

Each of the four categories listed above provide the format to address four life domains which include:

1. **Living Environment**
2. **Learning Environment**
3. **Working Environment**
4. **Social Environment**

The strengths-needs list consists of information learned from discussions with the consumer.

Strengths refer to what the client can do, if there are other people willing to help, and what community resources are available for the client.

Needs refer to what can be done; they should be stated positively in terms of what the client could be doing.

Sources (See Bibliography Appendix I):

Utah Department of Human Services, Field Guide for Community Mental Health Center Adult Case Managers, (March 2003).

Case 1

Carol is a 23 years of age. She has been in and out of the state hospital 8 times during the past 5 years. Her first hospitalization occurred when she was 17 years old. After a stay of 5 months, she was discharged, whereupon she spent 15 moths on the run, hitchhiking around the country. During this time she hooked up with Peter, a 24-year-old who had been homeless since age 15. Peter was an alcoholic who made some money as a street musician when he was sober. Carol learned to play back-up guitar for him. After spending some time in New Mexico, Peter left one day and never returned. Carol began traveling back home, mostly alone, but from time to time joining up with a male companion. On her return home, she lived alone in an apartment quite successfully for a few months. She learned carpentry and held a short-term job in the local furniture factory. From this experience she discovered that she enjoyed working with wood, and she started whittling as a hobby when she was not working. She returned to the hospital after a failed work experience, however, and lost confidence in her woodworking abilities. Her money eventually ran out, and she returned to her parents' farm where she helps with the chores.

Case 2

David is a 32-year-old who has been homeless for the past 2 years. He has a history of psychiatric hospitalizations. David has been visiting a day program 3 to 4 times a week for the past few months. He often hangs around after lunch and will participate in recreational activities when asked by staff. He says that he misses his old friends whom he no longer sees and generally talks a lot about the past. When not talking about the past, he talks about politics. He reads the newspaper whenever possible. David talks about wanting to find a job so that he can get the money to find a safe place to live. He wants to work in a boiler room, his last job before he was fired. David talks mist about finding a job after asking other people their age or telling others how old he is. He says frequently with a sigh that he is "getting old".

UNIT 8

PLANNING FOR SERVICES
THE SERVICE PLAN: DEVELOPMENT AND IMPLEMENTATION

Description:

This unit outlines goal planning techniques and guidelines to generate a Service Plan. The long and short term goals are based on the information obtained in the Strengths Assessment and prioritized on the Needs List. The Service Plan provides useful long-term and short-term goals and related actions steps that can be used to support the consumer's recovery process. The involvement of the consumer is critical to the entire process.

Objectives:

At the completion of this unit, participants will be able to:

1. Identify why goal setting is done.
2. Identify guidelines for goal setting based on the Assessment and Needs List.
3. Distinguish between life domains, long term goals and short -term goals.
4. Complete a Case Management Service Plan.

The Service Plan: Development and Implementation

Once a needs assessment is complete and needs have been prioritized with the consumer, the identified goals are recorded in a service plan.

What is a Service Plan?

A service plan is a set of action steps designed to achieve one or more of the client's goals as stated during the needs assessment.

It is a plan that contains:

- long term goals
- short term goals or action steps
- parameters of service delivery
- review date
- signatures of the client and case manager (and supervisor, if needed)

Just as the needs assessment is completed based upon the individual client, so is the service plan. Consequently, there are guidelines for completing the plan, but the design and emphasis of the plan is based upon the individual client.

The Role of the Case Manager in Designing a Service Plan

The role of the case manager is to:

- assist the client to prioritize his/her needs
- establish a goal statement(s) from his/her needs assessment
- identify the necessary action steps to accomplish the goal(s)
- design a plan that will support the client progress

Throughout this process the case manager educates and reinforces the client's right and responsibility to identify and make choices. Many clients have such low self-esteem that they feel unable to make important choices for themselves. The case management process should help them reclaim some confidence in their ability to choose. A variety of ways are used to increase consumer ownership of the Service Plan, examples include: consumer writes their own plan; consumer has a current copy; consumer signs the initial plan and subsequent changes; consumer reviews plan on a routine basis to monitor progress; and consumer learns how to use strengths to attain goals.

Each goal must be broken down into a set of action steps. These steps are listed along with who is responsible, and how and when the step will be accomplished. The art of designing a personal plan is to develop action steps that are small enough, and a plan of support large enough, so that disappointments and failures are minimized.

The following is a checklist for writing quality action steps:

- Are the action steps stated in positive terms?
- Are the action steps realistic and achievable?
- Are the action steps measurable and observable?
- Are the action steps stated in specific terms, not global terms?
- Are the action steps client oriented, not case manager oriented?
- Is the initial action step immediate with a high probability of success?
- Are the action steps set in sequential order and serve to accomplish a short-term goal?
- Are the number of action steps small enough to not overwhelm the client, but large enough to set a direction and set a challenge?
- Are the strengths identified in the assessment re-stated in the goals?

Once the needs assessment has resulted in a specific, time-limited service plan, the case manager and the client begin the exciting process of implementing the plan. Remember that nobody's life can be traced by a straight line! Expect that the plan will need to be changed and revised from time to time.

Implementing the Service Plan

The next step is implementation. Now the case manager and the client will utilize resources and services in the community to meet the goals on the Service Plan. The case manager will offer both practical support and encouragement throughout this process.

Offering Support to the Client

The most frequently expressed concern of new case managers is the perceived lack of progress of clients. The "revolving door syndrome," often addressed in literature and expressed in the field, describes clients who are discharged from the hospital into the community, then sent back to the hospital, only to begin the process again. It must be emphasized that the definition of a good case manager does not rest on client change. The ultimate attainment of client-based goals rests with the client, but the case manager and an active case management system are key players in eliminating obstacles to the client's progress. Growth and movement are supported by:

Celebrating Small Steps: Each time a client completes an action step a celebration is in order. The celebration may be as simple as acknowledging the success with direct eye contact and a verbal, "Good job, you did it."

Asking the Client How You Can Help: Helping a client attain goals requires just the right amount and kind of assistance. Sometimes helping can be unhelpful if it

conveys a message of incompetence or unworthiness. The case manager's job is to help in a way that strengthens the client and the relationship.

Staying in Touch: Depending on the resources of each CMHC, the client can generally make contact with a member of the case management team or another mental health professional 24 hours a day. Of course, the case manager is not on duty 24 hours a day. However, staying in touch often means following the client both into and out of crises, acute care and long term hospitalization. Active outreach to the client is a cornerstone of case management.

Go With the Flow: A case manager must support changes in client choice even it involves more time and energy in paperwork. Completing the small action steps, celebrating successes, building community supporters, rehearsing a problem solving process, and having someone they trust to help them survive in the community are the real goals. "'Going with the flow" requires not only patience but also a clear understanding of case management and a true commitment to serving clients.

Making Changes Which Address Lack of Progress

When progress through the goals stops, it is a signal that something is wrong with the goal that is not being achieved. A few questions may help the case manager and client diagnose the specific barrier(s):

1. Are the tasks not made discrete (small, specific) enough? Is the client expected to do too much?

2. Is the client too anxious to perform the task? Is more support needed? Should the tasks be restated?

3. Is the goal or task what the client wants? Does the goal or task need to be redefined or deleted?

4. Are significant others either being supportive or being non-supportive in regards to the client performing the task?

5. Is the client seeing progress in his life or is s/he facing a series of disappointments?

6. Is there so much change in the client's life that goal attainment is becoming overwhelming or stressful?

Discussion with the client will usually result in a clearer understanding of the barrier(s) to attainment. The supervision group could be involved in discussing the barrier(s) and generating alternatives for changing the steps toward attainment of the goal.

New Goals

After achievement of goals, with the client, determine new goals and follow the same steps toward achievement. This step does not require further elaboration except to note that as the client and case manager move on to new sets of goals, it is important for the case manager to continue to monitor the status of the client-resource linkages that have already been established. The ongoing performance of the client and the resource should be reviewed periodically by the case manager and the supervision group in order to direct immediate attention to any problems or barriers that may begin to appear. (University of Kansas, 1985)

Tracking and Evaluation

It is important that the case manager continuously track the status of all goals and evaluate if the desired goals were achieved and that no new problems have arisen because of the goal attainment process. Often, when clients move to a different status because of the accomplishment of one goal, problems with adjustment to this status can occur. For example, if a client has secured employment, the stress and circumstances (new expectations) need to be monitored as to potential difficulties which may be created in the client's life. Review and evaluate the status (needs, community linkage, living situation, medication use, etc.) of each ongoing case at least on a quarterly basis. (University of Kansas, 1985)

Client Burnout

The notion of **"client burnout"** is an important issue. As professionals, we see it all the time as it relates to "no shows," "medication non-compliance," and the "treatment drop-out" rates for our established programs. It is unrealistic to expect that clients would want to participate in treatment interventions unless they see signs of progress or understand how a specific activity relates to their current life situation. Clients with SMI may be particularly susceptible to this phenomena given the long history of treatment that many have experienced, the multiple "helpers" encountered, and the fact that they may feel no better off now compared to when they started their journey.

Incorporating a small step, goal oriented approach into our intervention strategies can instill the hope for change and create a partnership for this change to occur. It is important to establish some measurable goals which can be accomplished relatively quickly and to emphasize the progress made. Think how satisfying it is to cross something off a list. Identify ways that you can share that satisfaction with the consumer who has the most to gain from each achievement.

Closure

Closure or "termination" can occur when the client no longer wants to receive case management services or when the case has been successfully completed. In order to determine if a particular case is ready for closure, the following points need to be assessed:

- Has the client acquired the needed resources and skills? Are any other resources or skills needed to maintain the client in the community?

- How long a period of stability has the client experienced in the community? In assessing this question, it is essential to review (through case records) the cyclical nature of the client's history. Clients may experience distress around specific dates, stressors or issues in their life.

- Have you monitored the client's use of resources to insure that the relationships between the client and resources are secure and stable? How are problems resolved and have any new problems arisen?

- Have sufficient community supports been established to maintain the client-resource relationship? This could include using the family, neighbors and friends to provide supports and a telephone number of someone who can provide "on-call" assistance to the client in times of crisis.

- Has the client learned how to acquire resources to meet their goals? It may also include teaching the client how to set personal goals, break them into smaller steps, generate alternative resources, and how to approach the resource controllers.

Case managers must keep these five criteria clearly in mind while they plan and implement case closure. In a sense, the process of closure begins when a case is first received. The ending of a personalized relationship is difficult. Take time to process the closure issues that do arise. Remember that this can be an emotional time for both the case manager and client - use supervision. (University of Kansas, 1985)

Sources (See Bibliography Appendix I):

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UNIT 9

LINKING THE CLIENT TO SERVICES

Description:

This unit describes the crucial task of linking individuals with the resources they need to successfully implement their Service Plan. This unit also provides information about essential community resources and entitlements.

Objectives:

At the conclusion of this unit, participants will be able to:

1. Describe barriers to acquiring resources.
2. Identify case management roles.
3. Describe the CMHC as a continuum of care.
4. Identify local and state resources.

Linking Clients to Services

Because a crucial task of the case manager is linking clients with resources, the case manager must be familiar with the resources and key contact persons within particular agencies. This manual can help you become generally acquainted with state and local resources.

Resource acquisition plays a pivotal role in the case manager's intervention. One of the most common reasons why individuals experience an increase in symptom distress and/or return to a hospital is a lack of supporting resources or stress associated with deprivation. Under the tenets of the Community Support Program, reaching into the environment for needed concrete assistance and community involvement is a fundamental case management task.

Barriers to resource acquisition

There are many reasons why clients do not receive needed services or benefits. These include:

a) the case manager relies on untested assumptions or beliefs (e.g., assuming all requests for needed services or entitlements reflect a manifestation of an illness or personality "type");

b) favoring "treatment" over "environmental interventions" which leads to choosing only formal service/systems (mental health, social services, etc.) instead of developing options from the client's natural supports;

c) stigma, lack of knowledge, and restrictive requirements of program or provider;

d) lack of client skills associated with help seeking behaviors; and

e) a client's emotional or cultural barriers associated with attitudes and feelings about help seeking or program involvement.

Unfortunately, there are no uniform prescriptions about what constitutes an ideal "service package." This will depend on each individual's needs, local community resources and often means creating a unique package of resources and services within the natural community.

Case Management Roles

Implementer: It is not unusual for case managers to directly intervene with clients who may be experiencing extremely disruptive life events and who may be somewhat immobilized as a consequence. Loss of housing, the death or departure of a significant other, or loss of income, frequently precipitate temporary or episodic crisis. As an implementer, the case manager will often have to conduct a rapid assessment of the

need for environmental modification. This will typically involve temporary housing, income, or mental health care.

Teacher-instructor: This role may involve staff working directly with clients in developing skills which will enable them to become their own case managers so that they can subsequently fulfill their own needs. Teaching can include a variety of learning experiences, including review of interpersonal skills and techniques related to locating a place to live or employment, making friends, or negotiating benefits at a social service or entitlement program. This can be accomplished through direct suggestions, role playing and modeling.

Guide/collaborator: In this role, the case manager works with the individual to identify the resources or entitlements that the client requires to fulfill needs, and then guides the individual through the process of resource acquisition. This can include providing information and helping the client to exercise problem-solving skills, modeling ways to work with providers or program representatives, and staying with the client during the negotiation process to offer support and the possibility of later performance feedback.

Information specialist: Staff can facilitate resource acquisition by helping clients gain access to the specialized knowledge of human services, benefits systems, and other opportunities. In this role, staff helps clients to move through problem-solving, and also makes available staff's knowledge of community resources, appeals processes, and contact persons. An additional role can involve orienting clients to the use of information and other public access resource files. The implementations of these functions are less intrusive than some of the roles earlier described.

Enabler: Although this term has unfortunately acquired a bad reputation, being an enabler can mean that the case manager is willing to intervene to support a client's efforts at self-advocacy. This can include activities up to and including the use of staff influence to help the client access higher-ups in a service appeal process. Other steps which may be taken include providing psychological support and encouragement, imparting hope, and reinforcing small successes and progress.

Community Mental Health Center

It will be helpful for you to view the services offered at the CHMC as a continuum of care. The continuum allows a client to receive services according to his/her need. If the person's behavior is fairly stable and functional, he/she may only need outpatient services. But if his/her behavior is more volatile or out of control, he/she may need to use more intensive services such as hospitalization.

Outpatient services: These are individual or group counseling services provided by mental health professionals. These may involve discussing problems and solutions, providing emotional support, building relationship skills, and evaluating progress. These services include counseling for individuals, couples and/or families.

Emergency Services: These services are provided 24 hours a day for clients who are in crisis. Examples of such crises may include individuals who are experiencing suicidal thoughts, sudden attacks of anxiety or the death of someone important to them.

Therapeutic Rehabilitation Program (TRP): Therapeutic Rehabilitation Program services assure that a person with a psychiatric disability possesses those physical, emotional, personal, and intellectual skills to live, learn, and work in the environment of their choice. Services are designed for the development, acquisition, enhancement, and maintenance of social and personal adjustment, and daily living skills. Participants are encouraged to retain the fullest possible control of their lives, to set their own rehabilitation goals, and to fully participate in decisions affecting their own lives and future.

Medication Management: This service is provided by advanced registered nurse practitioners and/or psychiatrists. Psychotropic medications are prescribed to clients while the effectiveness of the medications is monitored by both the psychiatrist and/or psychiatric nurses.

Hospitalization: When a client's symptoms become so severe that they are a substantial danger either to themselves or to others, the client is generally hospitalized. The hospital provides a safe, secure environment where the client receives treatment that is more intensive. Each CMHC has a liaison with the state hospital in their area who will participate in the discharge planning.

Housing: There can be a range of housing services offered in the community or by the CHMC. Some housing provides treatment while others offer variable levels of support. For housing in the community, case managers need to become aware of both public and private resources, for example, the local public housing authority.

Representative Payee Services: Sometimes it will be determined that a client is unable to handle their own finances and a representative payee will be appointed. Payee resources in the community are often difficult to obtain. Many times, the case manager will need to advocate for this resource in their community.

Public Entitlement Programs: Many people with long-term psychiatric disabilities need assistance to obtain entitlements such as income support and special services for people without money. In most communities, the public and private social welfare system is fragmented, restrictive and characterized by complex intake and reporting procedures. It is the case manager's responsibility to know this system and the eligibility process. Often, applicants for social security benefits are turned down the first time they apply but they are eligible to appeal that decision. Clients should not hesitate to appeal unfavorable decisions.

Federally Administered Entitlement Programs

Medicare - Medicare is a federal health insurance program. Individuals who are 65 or older and those that receive SSDI benefits are automatically eligible for Medicare after they have received SSDI checks for twenty-four months.

Social Security Disability Insurance (SSDI) - This is a federally funded insurance program for the blind and disabled, funded by deductions from the applicant's payroll wages. Eligibility is based upon medical documentation of a disabling physical or mental illness. As with other insurance programs, a person must have contributed to it to receive payments later.

Supplementary Security Income (SSI) - This is a federal benefits program for the needy, aged, blind, and disabled. Eligibility is based upon medical documentation of a disabling physical or mental illness together with financial need. A thorough medical assessment and diagnosis with laboratory findings and other supporting evidence is required to support a successful application. It is in the client's best interest to appeal any findings of ineligibility, particularly at the first step. Entitlements are retroactive to the original date of application.

State Administered Entitlement Programs

Medicaid - This is a federal program to help low-income citizens with disabilities obtain medical care. Clients who qualify for SSI also qualify for Medicaid. Not all providers of medical service accept Medicaid, so you will need to become familiar with the providers in your area who accept this insurance.

Food stamps - now distributed as the EBT Card, are used to supplement individuals with low income. In emergency situations, they can be authorized and obtained within several days of application. Clients may apply for the EBT Card and others forms of state assistance at the local office for Community Based Services.

Community Resources

Besides the CMHC, each community has a variety of other services that will be crucial in assisting the client in fulfilling his/her goals. It is the responsibility of each case manager to learn the resources in their community that are beneficial to their clients and to assist the client in accessing and utilizing these community resources.

Sources (See Bibliography Appendix I):

Utah Department of Human Services, Field Guide for Community Mental Health Center Adult Case Managers, (March 2003).

UNIT 10

MONITORING AND ADVOCACY

Description:

This unit describes the final steps in the rehabilitation and recovery model of case management – Advocacy and Monitoring. It also provides guidelines for case monitoring and a review of grievance procedures in Kentucky.

Objectives:

At the conclusion of this unit, trainees will be able to:

1. Describe monitoring.
2. Identify common problems with monitoring.
3. Describe advocacy.
4. Describe the process for grievance procedures.

This unit describes the final steps of the strengths model of case management. Included in this unit are: monitoring and advocacy. Although this case management model is presented as a sequential step by step process, we know that interventions do not normally conform to a sequential approach. With this in mind, the iterative or circular focus of the model will allow for flexibility and provide for adjustments as needed by the client and case manager. As the case management work evolves, it is important for the case manager to remain focused, open to client initiatives and "new" needs, and continually assess the progress being made.

Monitoring

Case management is a fluid activity; case managers are community bound, not office based. To monitor service delivery, the case manager must actively watch, listen and interact with both the client and all the service providers. Monitoring must occur while the client is participating in services and programs. Monitoring involves being with the client in his/her natural surroundings as well as the treatment environments. Therefore the case manager might be at one of many locations – the client's home, any office of a service provider, a restaurant in the client's neighborhood or a clubhouse, to name a few. Case managers often receive the most current and reliable information if they make first-hand observations. Also, to be effective, case managers must develop solid working relationships with both clients and service providers.

Monitoring serves four global purposes (Moxley, 1989):

1. Ensure service coordination - At its best, it reviews programs and services not only for accountability, but also to see if everyone is addressing the same purposes stated in the Service Plan. Otherwise, the client may be exposed to discontinuous and/or conflicting interventions.

2. Determine achievement of the goals/objectives in the client's Service Plan - Through monitoring, the case manager can determine whether goals are being achieved, whether they are being met according to the plan's projected timeline(s), whether goals continues to fit the needs of the client, or whether there is a failure to achieve stated goals.

3. Determines service and support outcomes - Ongoing observations can trigger reconsideration of the plan and its recommended interventions when the Service Plan is not accomplishing its desired effects.

4. Identify the emergence of new needs - Monitoring enables the CM to stay in touch with the client. Monitoring provides consistent help to the client in identifying problems, modifying plans, ensuring the client has resources to complete goals, and tracking emerging needs.

When the case manager is monitoring a client's progress towards meeting the service plan goals, he or she will be attempting to answer these questions:

1. Is the client getting the services established by the service plan?
2. Are the services provided in such a way that the client can benefit from them?
3. Are the services provided to the client meeting the objectives of the service plan?
4. Are the services provided in a manner that is beneficial or usable to the client?
5. Are the plans objectives appropriate to the client's current needs, skills, and abilities?
6. Will meeting the plan's objectives give the client the ability to continue living in the community?
7. Does the client need additional services or intervention to be able to continue making progress?

The questions point to the effectiveness of the services and the appropriateness of the service plan. The answer to the questions will lead to the next action. And if the current service plan is not helping the client, a revised assessment and service plan may be in order.

Managing Day-By-Day

It is impossible to anticipate all the problems that might be encountered in case management work but certain problems seem to arise frequently. These include monitoring medications, personal money management, transportation, personal hygiene, medical and dental care, and employment training and opportunities. These will be addressed briefly below.

Medication Management

For many clients, medical evaluation is the essential form of help in preventing the recurrence of primary symptoms of mental illness, such as auditory hallucinations or voices. These medicines do not cure mental illness, but they can help control symptoms.

The evaluation, prescription and monitoring of psychiatric medicine are all the responsibility of the prescriber affiliated with each client. Prescribers include psychiatrists, APRNs and medical doctors. Part of that responsibility involves discussing the need for medication, its effects and its side effects with each patient. Psychiatric medicines are powerful medications. They can mean the difference between a person's ability to live in the community or the need to return to the hospital. They do not substitute for housing, income, social and work connections in the community.

As a case manager, it will be necessary for you to monitor a client's compliance with the medication regimen and report compliance to the rest of the treatment team. Case managers can advocate for the client in setting appointments, requesting an

unscheduled appointment with the physician or helping the client to get prescriptions filled.

Many clients view medications as helpful and they are anxious to collaborate with medical staff to maximize the most effective use of medication. Others resist the use of medication, some forget to take their medications, and some stop because they feel better without it or dislike uncomfortable side effects.

Case managers must remember that clients have the right to treatment and the right to refuse treatment, including medication. Except under very special circumstances, clients, like other citizens, have the right to do things that in the view of others are not good for them. Each case manager should discuss problems with medication compliance with the treatment team. A basic knowledge of psychiatric medicines will help case managers appreciate why clients take them, and sometimes refuse to take them. Case managers can consult with prescribers about medications.

Personal Money Management

Often a crucial area of case management is helping the client budget his or her financial resources. Living independently means new financial responsibilities that require self-discipline and saving for long-term purchases. Some suggestions to help case managers with budgeting are:

- Work with the clients to develop a list of priorities by helping them distinguish between needs and wants. Help them understand that money for the wants should come after the needs are taken care of.

- *DO NOT* push your judgments or values about money on to the client.

- Be careful to not "rescue." Work with the client to outline possible consequences (both positive and negative) for financial decisions.

- *DO NOT* use budgeting as a means of manipulation or punishment.

- Be aware of ethical concerns when dealing with clients on financial issues and consult with your supervisor.

Some clients will require a protective payee to manage their money. You, as the case manger, may be assigned this responsibility. Here are some additional guidelines if this is the situation:

- Continuously review the need for Representative Payee. Remember that a basic value of case management is to help clients be independent and gain more control over their own affairs. Encourage them to manage their own money as soon as possible.

- Know your agency policies and procedures about Representative Payee.

- Know the rules and regulations from Social Security about Representative Payee.

- Make sure to plan for holidays and vacations of staff. Clients should be able to receive their payments in spite of staff absences or agency closings.

Transportation

While providing case management services, you will frequently have clients in your (or the agency's) vehicle. Some points to keep in mind are:

- If you are able to drive personal vehicles for case management, check with your agency and your own personal insurance company to ensure proper coverage.

- Know and follow your agency policies about transporting clients. Discuss these policies with your supervisor.

- *DO NOT* transport clients alone whom you believe are a safety concern.

Hygiene and Grooming

Adequate hygiene and grooming are problems for many clients. Case managers must carefully assess hygiene needs being careful to not push their own values on clients. DO NOT tell a client they need to "get a haircut" or "clean up." People with a mental illness, like other people, do not respond positively to accusations or inferences that they are dirty or unattractive. Advice like this will most often result in hurt feelings and will fail to change behavior. Intervention by the case manager should be preceded by a nonjudgmental and thoughtful assessment of the possible reasons for poor hygiene and grooming, health concerns associated with hygiene issues for the client and others, and ways to help with these problems.

What are some of the reasons behind these problems?

⇒ The most obvious answer to this is a lack of money. People living on fixed incomes from government benefits often prioritize their spending to include many other needs before hygiene needs. Often they purchase second-hand clothes or accept donations of used clothes to conserve their monies.
⇒ Second, they attend to other more pressing concerns, including their symptoms.
⇒ Third, Laundromats may not be easily accessible and they are always expensive.
⇒ Fourth, they may not have anything or anybody for whom to clean up or dress up. They may see no reason to improve hygiene and grooming.
⇒ Finally, poor grooming and hygiene often reflects the low self-esteem that commonly accompanies mental illness.

A major goal of the case management relationship may be to help the client discover resources and develop good reasons for caring about his/her appearance and hygiene. Occasionally, hygiene problems may directly threaten personal health or the health of others such as children. In such situations, case managers must take reasonable steps to insure health and safety, and consult with their supervisor.

Medical and Dental Care

Adequate, timely medical and dental care is often a problem for clients. Again, a common obstacle is poverty, not necessarily mental illness. Clients often do not have medical coverage and therefore do not seek medical services. The case manager needs to know the local resources for individuals without medical coverage. Sometimes low-cost or no-cost services can be obtained for needy individuals from local professional or service organizations or from colleges or universities in your area.

Families of clients and other clients are often invaluable resources to individual clients and to the case manager. They know the history of mental and physical health problems, the treatments and responses. They may be able to propose approaches that have worked in the past. Families can be a resource in managing these needs and case managers are encouraged to work with the family to manage client's needs.

Advocating for Clients

In the role of an advocate, the case manager attempts to bring about solutions to problems impeding the client's progress or infringing on his/her rights. The case manager also teaches the client to be a strong advocate for themselves. Additionally, the case manager develops a network of community collaborators for advocacy. Community collaborators are resourceful, caring, and responsible individuals who are committed to the growth and development of the client. Often these collaborators are family members, friends, neighbors, and community agency personnel. By meeting regularly with the client and with collaborators, barriers to client progress can be identified and steps can be taken.

- The case manager and the client must always have a clear understanding of what the problem is. As an advocate, the case manager's primary role is to help the client to obtain what he or she wants. Case managers must not substitute their own ideas of "what is best" for clients.

- The case manager respects the dignity, self-worth and self-determination of the clients and, in all ways, attempts to enhance them.

- The case manager supplies the client, to the best of his/her ability, with tools required for the client to exercise control over his/her destiny.

Advocacy takes place at different levels of the service system. For example, the case manager may go with the client to reapply or submit an appeal for financial assistance,

or a case manager may approach a public housing authority about developing low-income housing in rural areas. Advocacy is important. Through the process of case management, positive and long-term improvements for the clients can be made.

It is important to remember that clients are, in a real sense, your customers. They are customers of the community mental health center, housing programs, rehabilitation agencies and all the services and organizations that comprise the community support network. As customers, paying directly for services or authorizing payment from government sources, clients have the right to be treated fairly, competently and with dignity from any services provider. Clients have the right to equal treatment regardless of their age, sex, race or ethnic origin. They have the right to have communication with therapists held in strict confidence, except for a few specific exceptions, and they have the right to participate in the development and review of their service plan goals and methods. Their rights may need to be asserted through administrative or legal appeal.

Grievance Procedures

Grievance procedures refer to accepted administrative methods of solving problems or registering complains. Mental health institutions and agencies should have grievance procedures clearly stated and have them publicly posted. Any client has the right to know what these procedures are and to utilize them without fear of punishment. As a case manager, you may assist a client in using the grievance procedures of an agency. In Kentucky, all fourteen regional MHMR Boards have a client grievance procedure clearly written and posted at each site. Clients have the right to have the grievance procedure explained in language they can understand, a right to ask for help in filing the grievance, and a right to make the complaint to someone other than their primary therapist.

If the client is dissatisfied with the outcome of the grievance procedure, they have the right to appeal using their Regional MHMR Board's internal appeal process. Finally, if the client is not satisfied with the final decision of the MHMR Board's internal appeal, a grievance may be filed with the Cabinet for Health and Family Service's Ombudsman at 1-800-372-2973 or 1-800-627-4702 (TTY).

Sources (See Bibliography Appendix I):

Utah Department of Human Services, Field Guide for Community Mental Health Center Adult Case Managers, (March 2003).

UNIT 11

SUPERVISION AND TAKING CARE OF YOURSELF

Description:

This unit describes the team process through group supervision as well as the importance of on-going individual supervision. This unit also reviews time management and stress management concerns that effect case managers daily.

Objectives:

At the completion of this unit, participants will be able to:

1. Identify three advantages of group supervision.
2. Understand the role of case manager supervisors.
3. Understand the role of case managers in supervision.
4. Describe how group supervision can be used to assist in goal planning.
5. Understand the importance of taking care of yourself in order to provide quality services to your clients.

Group Supervision

In the Rehabilitation and Recovery model of case management, case managers plan and learn as a group under the supervision of a professional experienced in working with persons with severe mental illness.

There are three strong advantages to this group model of supervision:

First, research has found that in order to provide good quality service to this population, highly individualized plans must be developed for each client. This requires a high degree of creativity which is difficult to achieve consistently as an individual worker. However, the **"brain storming" method of problem solving and generating alternatives** is not only highly effective, but can also be very exciting and challenging to those involved in it.

Second, in addition to the group supervision model resulting in a higher quality of individualized planning, and therefore service, it is also **an effective way of exchanging information** (e.g., what resources exist and how to gain access to them) **and of learning**. Case managers learn ways of understanding many client situations and needs in addition to the cases for which they are directly responsible. Client needs and goals can be behaviorally anchored to the various perspectives that the individual team members bring to the group. This enhances the learning possibilities for the team members and provides a rich outlook in terms of the change strategies available to the client.

The third advantage of this group model is that it has the **potential to decrease the level of "burnout"** that case managers may experience. As case managers become involved in one another's cases, there is an opportunity to share successes and challenges, which provides a much higher level of support than would be possible without the group. Frustrations can be ventilated from the perspective of understanding that other team members can understand the level of challenges that case management work entails.

Roles of Case Management Supervisor

- **Consultant**--First line consultation. It is better to talk out ideas before trying them. You may help case managers to work with consumers to establish short term goals that will show progress.

- **Counselor**--Supervisors are not therapists for their staff. However, it is appropriate to help workers through stressful times by reflecting, showing empathy, building rapport, and facilitating growth.

- **Teacher**--Model and teach skills. This is an on-going process which needs patience and preparation. When you identify a need to learn, check it out with the group. Determine who should present what information at the next group supervision.

- **Supervisor**--Understand your role and its limits. Be clear and model a strengths model value base, energy, and a "can-do" attitude. Show respect and loyalty.

- **Administrator**—Provide agency updates and overall requirements that will assist case managers in completing tasks efficiently and decrease isolation.

- **Colleague**--You share common professional goals even when other professions don't think alike.

- **Facilitator**--You are a catalyst for the case managers. (But not all things to all people.) You can assist the group in identifying client specific or system specific issues and strategize ways to move forward. You can refocus a difficult group supervision session by asking each case manager to share a goal a client achieved or an experience that caused "a bright case management moment".

Roles of Case Manager

Because of the high level of involvement that case managers have in the work and learning processes, there are certain basic rights and responsibilities that accompany membership in the case management team. Some of these are listed below.

- All members are expected to participate both in listening to and contributing ideas. No ideas are too "silly, absurd, or simple" to be useful and, in fact, ideas that may seem to initially fit one of these descriptors are often the seeds of the best plans.

- Each member will find that there are areas in which they have skills and areas where they have skill deficits. It is important to remember this and to be willing to bring problems, apprehensions, frustrations, confusion and/or recommendations to the group for help. That is a part of the learning process.

- Because the team may spend a great deal of time together, it is important to promote a comfortable, informal atmosphere. Humor is a vital part of such an atmosphere. The ability to laugh is a survival skill.

- All members are expected to accord the other team members the same respect and sensitivity to which you are entitled.

- Approach the group process with an open mind. Remember that personal biases do exist. It is important to acknowledge these biases but also be willing to set them aside. By letting go of stereotypic notions, freedom to enter into the creative process of exploring intervention alternatives will be enhanced.

Goal Planning

The sequence of steps in goal planning (unit 7) has been designed to maintain a high level of client involvement and to protect the client against the imposition of goals by others. However, sometimes a situation is so complicated that you feel lost in assisting the client to identify achievable goals. The supervision group can provide a viable source of assistance. Each supervisory group session should include an opportunity to address specific cases. The following is an example of how to include this process:

Discuss the strengths assessment data and needs list. Once the assessment and needs list have been completed and an initial goal is established with the client, the case manager may present this data and their impressions to the case management team. Presenting your impressions involves describing in behavioral terms what the client's world is like. Given the information that you have obtained, envision yourself in the client's position and discuss how the world might be perceived from their perspective. It is important not to strictly relate stories about the client's life. Relating client stories on a continual basis has the potential effect of limiting your creativity and avenues for intervention.

Impressions should center around the struggles, concerns, hopes, fears, strengths, and outlook on life that the client presents. This demands that you view the world through the client's eyes. A greater awareness and understanding of the client's current situation can unfold from this perspective. Also, it is more likely that the client will be viewed as a human being and not objectively described as another case to be processed. With the assistance of the supervisor, the group will be able to grasp the overall picture of the client's lifestyle and the client's subjective experience of that lifestyle.

Discuss setting long and short term goals. This can occur before or after consumer and case manager have completed the plan in Unit 7. First the group has an overall understanding of the client and their situation. Then the group reviews the overall picture of the way in which the client would like their life to be (i.e., long term goals), and identifies what the client and case manager can realistically expect to achieve in a few months of work (i.e., short term goals). It is important that we not impose limitations on, or set up a negative self-fulfilling prophecy for, the client's hopes or aspirations. However, it is equally important that we assist clients to set immediate (short term) goals that can realistically be accomplished in order that the client, as well as the case manager, experience success rather than failure.

The case manager, with the assistance of the group, can ensure that the short term goals are realistic, but that they are leading toward the client's long term goals which may seem unrealistic based on the assessment of the current situation.

Alternative Group Strategies

The strengths model of case management outlined in this manual is designed to utilize group supervision or the team concept as a means of enhancing the intervention strategies available to case managers and clients. The group process is intended to be flexible depending upon the level of staff expertise and situational needs. For example, with a new staff, initial group sessions may focus on more formalized presentations of local resources, strengths, assessment, etc. Through these formal presentations, staff members can be familiarized with a number of assessment strategies and how to conceptualize client strengths which will begin to focus the intervention strategies. As the group becomes more comfortable working together as a team, the formalized nature of the group process will decrease. It is important that the group members perceive the group as a time for mutual creativity and support to enhance their effectiveness in working with persons with SMI.

It is important to also identify needs of group members. For example, if case managers discuss concerns about communicating with someone who is hallucinating, the group may chose to watch a video during their next meeting to enhance their skills or, if psychotropic medications are causing confusion, a staff nurse or community pharmacist may be invited to provide a brief presentation.

Taking Care of Yourself

Working with people can be stressful. Working with persons who are low income and who suffer from severe mental illness can be even more stressful. It is important to take care of yourself – physically, emotionally, and socially. You may have opportunities to attend time management and stress management workshops. They will go into more detail about coping with the challenges of your job.

But here is a list of suggestions that may be useful:

Time Management

- Make a daily plan of tasks.
- Prioritize the list. Identify those tasks that have to be done today (A's) from those which should be done, but could be done tomorrow (B's) and those which are not that important (C's).
- Be sure to do your "A" tasks first.
- Keep lists simple and realistic.
- Carry your list with you – consult it often.
- Let your list be your guide, not a ball and chain. You will find that you often have to adapt and revise.
- Let the clients know when you will have time to provide transportation, go shopping, etc. Set appointments with them and stick with it. If they are not there for the appointment, make another appointment for another time. They will soon know they can rely on you.

- Be on time. Treat clients the way you want to be treated.
- Make a "grass-catcher" list. This is an ongoing list of things to be done, but do not have a specific deadline. When you are making your daily to-do list, consult this "grass-catcher" list.
- Always ask "what is the best use of my time right now?"
- Do not do other people's "A" tasks at the expense of your own.

Stress Management

- Talk with co-workers and your supervisor about your experiences and feelings. Sharing with others helps to reduce the tension and find humor in difficult situations.
- Learn how to use relaxation exercises.
- Use humor appropriately.
- Recognize the stages of burnout.

<u>Stage I – Early Warning Signs</u>
Vague anxiety
Constant fatigue
Feelings of depression
Boredom with one's job
Apathy

<u>Stage II – Initial Burnout</u>
Lowered emotional control
Increasing anxiety
Sleep disturbances
Headaches
Diffuse back and muscle aches
Loss of energy
Hyperactivity
Excessive fatigue
Moderate withdrawal from social contact

<u>Stage III – Burnout</u>
Skin rashes
Generalized physical weakness
Strong feelings of depression
Increased alcohol intake
Increased smoking
High blood pressure
Ulcers
Migraines
Severe withdrawal
Loss of appetite for food
Loss of sexual appetite
Excessive irritability
Emotional outbursts
Irrational fears (phobias)
Rigid thinking

<u>Stage IV – Burnout</u>
Coronary artery disease
Asthma, Diabetes
Cancer, Heart attacks
Muscle tremors
Suicidal thoughts
Severe depression
Lowered self-esteem
Inability to function at job/home
Uncontrolled crying spells
Severe withdrawal
Severe fatigue
Over-reaction to emotional stimuli
Agitation, Constant tension
Feelings of hostility
Accident proneness/carelessness

- Take action to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.

- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits for yourself and others. Know your own boundaries.
- Exercise regularly.

“Often the person who identifies himself as the curer or fixer-type healer is vulnerable to burnout.” *(Rachel Naomi Remen, M.D.)*

“Perhaps the most important thing I have learned from my work is that I can be a friend and supporter of healing; I can be a guide to people; but it is not I who does the healing. I try to heal by creating situations that seem to allow or foster healing – calmness, faith, hope, enthusiasm – and sometimes just the idea that healing is a possibility.” *(Martin Rossman, M.D.)*

Sources (See Bibliography Appendix I):

Utah Department of Human Services, Field Guide for Community Mental Health Center Adult Case Managers, (March 2003).

Appendix I
Kentucky Adult Case Management
Level I
Training Manual

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Appendix II

Kentucky Adult Mental Health Case Management Level 1 Training Manual

Curriculum

Unit 1 Introduction to Community Support Programs and Case Management • Introduction • History of Mental Health Treatment • Moral Treatment and Asylums • Custodialism • Deinstitutionalization and the Community Mental Health Center Movement • The Community Support Program • CSP Principles • Kentucky's CSP History • Kentucky's Vision • Kentucky's Philosophy • Vision, Mission, Values • Definition of Case Management • History of Case Management in Kentucky	Participants will be able to: • Identify a brief history of mental health treatment for adults with a severe mental illness. • Describe the origins and principles of the Community Support Movement. • Describe Kentucky's vision and philosophy for services to adults with severe mental illness. • Define Case Management. • Describe Kentucky's mental health adult case management history.
Unit 2 Mental Illness: Definition and Eligibility – Who are Consumers of Case Management Services • Definitions of Mental Illness 1. Federal Definition 2. KY Statutory Definition • Criteria for Severe Mental Illness 1. Diagnosis 2. Disability 3. Duration • Presentation of Severe Mental Illness 1. Psychotic Disorders 2. Mood Disorders 3. Personality Disorders	Participants will be able to: • Discuss the federal and Kentucky state definitions of severe mental illness. • Describe the three dimensions used as criteria to determine severe mental illness -diagnosis, disability and duration. • Discuss the presentation of severe mental illness.
Unit 3 Case Management Practice • Models of Case Management Practice 1. Broker Model 2. Strengths Model 3. Rehabilitation Model 4. Assertive Community Treatment Model • Levels of Case Management Practice • Definition of Case Management • Functions of Case management • Critical Elements of Case Management Practice	Participants will be able to : • Describe four case management models. • Describe three levels of case management. • Define intensive case management. • Identify functions of case management. • Identify critical elements of case management practice.

UNIT 4 A Recovery Oriented Service System • Recovery • Recovery Definitions • Recovery Oriented Service System • Assumptions about Recovery • Essential Services in a Recovery Oriented System • Characteristics of a Recovery Oriented System • Key Concepts in Recovery	Participants will be able to: • Define recovery. • Recognize assumptions about recovery. • Describe the four key concepts in recovery. • Describe a recovery-oriented system of care.
UNIT 5 Kentucky Case Management Rehabilitation & Recovery Model • Kentucky Case Management Rehabilitation & Recovery Model • Key Values of the Strengths Model of Case Management • Principles of the Strengths Model of Case Management • Key Rehabilitation Values • Principles of Psychiatric Rehabilitation • Major Activities of the CM Process 1. Coordinating 2. Advocating 3. Linking 4. Monitoring	Participants will be able to: • Describe the values and principles of the Strengths Model of Case Management. • Describe the values and principles of Psychiatric Rehabilitation. • Describe the four major activities in the case management process.
UNIT 6 Coordinating With And For Clients • Case Manager – Consumer Relationship • Engaging and Connecting • Boundary Issues and Ethical Guidelines • Clients Rights • Confidentiality	Participants will be able to: • Describe the essential elements of a case manager – consumer relationship. • Discuss boundary issues and NACM ethical guidelines. • Describe general client rights issues. • Articulate the philosophy behind the Assurance of Case Management Services Certification Form. • Explain confidentiality issues and principles.

UNIT 7 Planning For Services
Assessment: Strengths, Needs, and Priorities
 	
• Overview
• Multiculturalism
• Eleven Principles of Multiculturalism
• Planning For Services: The Assessment Process
• Developing a Strengths Assessment
  o Introduction & Exploration
  o Empowerment & Acceptance
  o The Strengths Assessment Discussion
  o Prioritizing Needs
• Elements of the Case Management Strengths Assessment Form
  1. Basic Information
  2. Strengths Assessment
  3. Current Status
  4. Personal Goals
  5. Resources (internal/external)
  6. Needs
• Four Life Domains
  1. Living
  2. Learning
  3. Working
  4. Social
	Participants will be able to:
	
	• Understand the concept of multiculturalism and the need for culturally competent practice.
	
	• Explain the difference between a strengths assessment and a diagnostic assessment.
	
	• Describe the process to complete a case management strengths assessment.
	
	• Complete a case management strengths assessment.

UNIT 8 Planning For Services **The Service Plan: Development and Implementation** • The Service Plan: Development and Implementation • What is a Service Plan? • The Role of the Case Manager in Designing a Service Plan • Implementing the Service Plan • Offering Support to the Client • Making Changes Which Address Lack of Progress • New Goals • Tracking and Evaluation • Client Burnout • Closure	Participants will be able to: • Identify why goal setting is done. • Identify guidelines for goal setting based on the assessment and needs list. • Distinguish between life domains, long-term goals, and short-term goals. • Complete a Case Management Service Plan.

UNIT 9 Linking The Client To Services • Linking Clients to Services • Barriers to Resource Acquisition • Case Management Roles • Community Mental Health Center • Federally Administered Entitlement Programs • State Administered Entitlement Programs • Community Resources • Housing Resources	Participants will be able to: • Describe barriers to acquiring resources. • Identify case management roles. • Describe the CMHC as a continuum of care. • Identify local and state resources.
UNIT 10 Monitoring and Advocacy • Monitoring • Monitoring serves 4 Global Purposes • Managing Day-By-Day 1. Medication Management 2. Personal Money Management 3. Transportation 4. Hygiene & Grooming 5. Medical & Dental Care • Advocacy for Clients 1. Grievance Procedures	Participants will be able to: • Describe monitoring. • Identify common problems with monitoring. • Describe advocacy. • Describe the process for grievance procedures.
UNIT 11 Supervision and Taking Care Of Yourself • Group Supervision • Roles of Case Management Supervisor • Roles of Case Manager • Goal Planning • Alternate Group Strategies • Taking Care of yourself o Time Management o Stress Management o Burn Out	Participants will be able to: • Identify three advantages of group supervision. • Understand the role of case manager supervisors. • Understand the role of case managers in supervision. • Describe how group supervision can be used to assist in goal planning. • Understand the importance of taking care of yourself in order to provide quality services to your clients.

Appendix III

Kentucky Adult Mental Health Case Management Level 1 Training Manual

CM Forms

CASE MANAGEMENT STRENGTHS ASSESSMENT

Client:_____ Age:_____ Sex:_____ Date:_____

Address:_____ Social Security #:_____

Case Manager:_____ Client #_____ Medicaid #_____

Date of most recent Discharge from institution:

Marital Status

____Divorced/annulled

____Widowed

____Separated

____Common law/Living together

____Married

____Never Married

____# Children - Ages:

____How many in house

Educational Status
(check all that apply)

____1 to 5 years

____6 to 8 years

____9 to 10 years

____11 to 12 years

____GED

____Trade/vocational/training

____College

____Graduate school

____Other_____.

Race/Ethnicity

White _____

Black_____

Hispanic_____

Native American_____

Other_____

First Language_____

Second Language_____

Sources of Monthly Income	None	Amount
SSI:_____ or SSD_____	_____	_____
Employment:	_____	_____
Vocational program:	_____	_____
Unemployment compensation:	_____	_____
T.A.N.F/AFDC:	_____	_____
Food stamps	_____	_____
Alimony/child support	_____	_____
Family/spouse contribution	_____	_____
Military service Disability	_____	_____
Pension, social security, retirement, etc.	_____	_____
Other source (specify)	_____	_____
	_____	_____

Monthly Expenses	Amount
Rent	_____
Utilities	_____
Others:	_____
	_____
	_____

	Yes	No
Medicaid	_____	_____
Medicare	_____	_____
Private insurance	_____	_____

Other information: (Should include legal status)

CASE MANAGEMENT
STRENGTHS ASSESSMENT

_____ _____

CASE MANAGER NAME, TITLE DATE **CLIENT NAME ID NUMBER**

CURRENT STATUS WHAT'S GOING ON NOW?	PERSONAL GOALS WHERE I'D LIKE TO BE?	RESOURCES: INTERNAL/EXTERNAL WHAT HAVE I USED? WHAT CAN I USE?	NEEDS WHAT STEPS DO I TAKE TO GET THERE?
Filling out these two columns in each of the life domains will provide for a good consumer assessment.		**Filling out these two columns will help develop a foundation for a good consumer-driven personal plan.**	
LIVING ENVIRONMENT: MY LIVING SITAUTION			
LEARNING ENVIRONMENT: MY EDUUCATIONAL AND LEARNING INTERESTS ARE…			

CASE MANAGEMENT
STRENGTHS ASSESSMENT

CASE MANAGER NAME, TITLE **DATE** **CLIENT NAME** **ID NUMBER**

CURRENT STATUS WHAT'S GOING ON NOW?	PERSONAL GOALS WHERE I'D LIKE TO BE?	RESOURCES: INTERNAL/EXTERNAL WHAT HAVE I USED? WHAT CAN I USE?	NEEDS WHAT STEPS DO I TAKE TO GET THERE?
Filling out these two columns in each of the life domains will provide for a good consumer assessment.		**Filling out these two columns will help develop a foundation for a good consumer-driven personal plan.**	
WORKING ENVIRONMENT: I SPEND MY TIME...			
SOCIAL ENVIRONMENT: WHO IS IMPORTANT IN MY LIFE			

NEEDS LIST

NEEDS **(From needs section of the assessment tool)**	**PRIORITY** **(1 = highest)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

INITIAL TASK:

_____

_____

_____

Case Manager's Name	Date

PERSONAL PLAN

Client's Name	ID #

Life Domain (check one): ☐ Living Environment ☐ Learning Environment ☐ Working Environment ☐ Social Environment

Long Term Goal:

Short Term Goals and Action Steps	Responsibility for C/CM/Specialist	Date to be Accomplished	Date Accomplished	Comments
Short term goal:				

_____ _____ _____ _____

Client Signature date Case Manager Signature date